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ABSTRACT

A 1982-83 manual on school-based occupational therapy and physical therapy (OT/PT) services in Texas is presented. Contents include: guidelines, evaluation forms, student and therapists' documentation forms, and policy/procedures manuals for a suburban independent school district and a rural independent school district. Part I provides the official guidelines of the American Occupational Therapy Association; Texas guidelines for service delivery in educational settings; information on referral, evaluation, and equipment; and a list of Harris County organizations and national organizations. In addition to instructions and forms for evaluation and school screening reports, Part II presents background information and forms on in-depth evaluations. Many, but not all, of the evaluation inventories are accompanied by information on the test, including publisher, author, age range, purpose, testing time, scores, reliability and validity, content, subtests, and norms. These evaluation forms and tests cover the following areas: developmental (five instruments), self-help (six), reflex (three), clinical evaluation (eight), prevocational (two), sensory integration (nine), and additional standardized evaluations (eight). Additional procedures and forms include: updates to the Individualized Education Program and OT/PT summary reports, OT/PT schedules; home-school program forms, therapists' field observation forms, and employee performance reports. Supplementary materials cover the role of the lead therapist and three models of consultation. The manuals for the suburban and rural school districts in Part III describe services and procedures, and each provides 10 to 17 forms, along with supporting documentation. (SEW)

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# OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

## SCHOOL BASED PROGRAMS

HARRIS COUNTY SCHOOL SUPERINTENDENT

EQUALITY

EXCELLENCE

## AN ORGANIZATIONAL MANUAL

## 1982-83

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# OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

## SCHOOL BASED PROGRAMS

## ORGANIZATIONAL MANUAL

This is a special project of the Psychological Services Division of the Harris County Department of Education, compiled and/or edited by: Marlene McKee, M.Ed., Executive Director of Psychological Services, Karla da Cunha, M.A., Co-ordinator, Linda Echols, LPT, Assistant Co-ordinator, Carolyn Starr, LPT/OTR, Assistant Co-ordinator, Donna Naskrent, OTR, Program Assistant, Joyce Urbanovsky, OTR, Program Assistant.

# FOREWORD

This Department is a service agency which has provided comprehensive related services to special education programs in Harris County for many years. In 1975, occupational therapy was added to the array of services, soon followed by physical therapy.

The 1978 implementation of PL 94-142 in Texas resulted in great increases in requests for both OT and PT services from this department. We increased from one OT to over fifty OT/PT personnel in seven school years.

This, of course, generated significant program development and management strategies. The outcome of these endeavors is presented for your consideration. Please use what you wish. We hope it will be helpful!

Marlene McKee, M.Ed.
Executive Director
Psychological Services Division
Harris County Department of Education

# DEDICATION

This working model is dedicated to all those diligent and caring therapists who have contributed to its design, growth and implementation during the past several years. Their suggestions, encouragement, and support, made this book possible!

Section III was developed in cooperation with school district programs and personnel...Special Education Directors, Coordinators, Supervisors, diagnostic personnel, nurses and teachers. Thank you for your patience, understanding and fine contributions!

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# PART I

## STATEMENT OF PHILOSOPHY

The "right to a free appropriate public education which emphasizes special educational and related services designed to meet their unique needs" has been assured to all handicapped children by the enactment of Public Law 93-112, Section 5 of the Rehabilitation Act, and Public Law 94-142, Education for all Handicapped Children Act. The unique instructional and physical needs of handicapped children may interfere with the total educational process. The OT/PT, with skill and knowledge acquired through specialized and extended education, may assist in the identification and management of unique problems that interfere with learning. The sharing of information between the OT/PT and the educator can provide a learning environment which enables the child to develop his potential in the educational setting.

In contrast to the usual practice of providing OT/PT services in a separate therapy setting, therapists in educational environments should utilize the classroom setting whenever possible. This helps insure functional usefulness and the generalization of skills to the environment in which they are needed. The OT/PT providing services in educational environments should facilitate coordination of students' school therapy programs with existing community therapy programs to assure total programming and avoid duplication of services.

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## ABBREVIATIONS/DEFINITIONS

This list is to acquaint you with abbreviations and definitions and/or words which you will find throughout this manual.

| | |
|---|---|
| A.D.L. | Activities for Daily Living |
| AOTA | American Occupational Therapy Association |
| APTA | American Physical Therapy Association |
| ARD/IEP | Admission, Review and Dismissal/Individualized Educational Plan: a committee meeting |
| Assistant Coordinator | Supervising Therapist with administrative responsibilities |
| DAP | Directed Activity Program: a written program given to a teacher/aide/parent for a specific student |
| Harris County | A geographic county of Texas, divided into 20 independent school districts |
| HCDE | Harris County Department of Education |
| ISD | Independent School District |
| Lead Therapist | The designated therapist in a district whose responsibilities also include the dissemination of materials both written and verbal between HCDE and the district |
| NCR | no carbon required |
| OT/PT | Occupational Therapy(ist) and/or Physical Therapy(ist) |
| Program Assistant | Supervising Therapist, who have demonstrated clinical and leadership capabilities |
| R.S.D. | Rural School District |
| S.S.D. | Suburban School District |
| T.E.A. | Texas Education Agency |
| Tracking | A system designed to ensure that all necessary dates and reports are documented for each student |
| U.S.D. | Urban School District |

# OFFICIAL AOTA GUIDELINES AS ADOPTED APRIL, 1980

## STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY IN SCHOOLS

These guidelines are to assist AOTA members and school administrators in the management of occupational therapy in the school systems. These standards by themselves cannot be interpreted to constitute a standard of care in any particular locality.

The occupational therapist shall manage the therapy program in accordance with all available STANDARDS OF PRACTICE, as defined by the American Occupational Therapy Association, Inc.

The purpose of the Occupational Therapy program in the school system is to enable the student to gain optimum benefit from the educational program.

## DIRECT SERVICES

Direct services include screening, referral systems, evaluations, program planning, program implementation, re-evaluation and termination of services.

### Standard I: Screening

THE OCCUPATIONAL THERAPIST SHOULD BE INVOLVED IN THE SCREENING PROCESS.

1. The screening process should allow the therapist to identify those students who need further educational and/or related service evaluation.
2. All screening methods shall be appropriate to the chronological, educational and/or functional level of the student, and shall not be racially or culturally discriminatory.
3. The occupational therapist should refer the results and recommendations to the appropriate school educational planning committee.

### Standard II: Referral

A REFERRAL FOR OCCUPATIONAL THERAPY MUST COMPLY WITH THE AOTA STATEMENT ON REFERRAL.

1. A student should be referred to the occupational therapist for evaluation when the student has or appears to have a dysfunction in any of the following areas:
   a. Occupational performance (activities of daily living); self-care activities; home-school work activities; play/leisure activities; and/or pre-vocational/vocational activities/skills.
   b. Performance components: neuromuscular development; sensory integrative development; psychological development; social development; and/or cognitive development.

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2. A referral may originate through the individual educational plan or educational planning committee (including teachers, other student services staff, parents, physician, etc.).

3. When a referral is received, the therapist shall document:

   a. The date of receipt and referral source.

   b. Services requested in the referral.

*4. If in the therapist's judgement there is the need for medical management of the student, the therapist shall immediately apprise the student's parent/guardian or appropriate person and recommend physician involvement, or the therapist shall, after parental/guardian written permission or release has been obtained, contact the physician.

## Standard III: Evaluation

THE OCCUPATIONAL THERAPIST SHALL EVALUATE THE STUDENT'S PERFORMANCE.

1. The initial occupational therapy evaluation shall be complete and results documented according to the time frames established by federal and/or state rules and regulations.

2. The occupational therapy evaluation shall include assessment of the developmental level as well as the functional abilities/capacities and deficits/limitations as related to the student's educational level and needs in the following areas:

   a. Occupational performance: self-care activities; home-school-work activities; pre-vocational/vocational activities/skills, and/or play/leisure activities.

   b. Performance components: neuromuscular development; sensory integrative development; psychological development; social development and/or cognitive development.

*3. If the results of the above evaluation indicate possible deficits in psychological/social, cognitive, physical/medical, speech/language areas, the therapist should refer the student to the appropriate services and/or request consultation if necessary.

4. All evaluation methods shall be appropriate to the chronological age and/or functional level of the student and identify baseline behaviors. The methods may include, but need not be limited to observation of activity performance, interview, record review, testing and individual/group screening.

5. If standardized evaluative measurements are used, the tests should have normative data for the age range of the student. If normative data are not available for the age range of the student, the results should be expressed in a descriptive report and standardized scales not used.

6. Tests and other evaluation material used in placing handicapped students will be prepared and administered in such a way as not to be racially or culturally discriminatory, and they will be presented in the child's native tongue.

7. As part of the evaluation process, the therapist may make clinical judgements, based on observations and recorded progress during intervention programs.

8. The therapist shall document evaluation results in the student's record, indicating evaluation instruments and procedures and also communicate these findings via written reports, oral conferences, and staffings to the appropriate persons and/or community resources.

Standard IV: Program Planning and/or Individual Educational Plan

THE THERAPIST SHALL PREPARE AND DOCUMENT A PROGRAM PLAN BASED UPON AN ANALYSIS OF THE DATA FROM THE OCCUPATIONAL THERAPY AND OTHER EDUCATIONAL PLANNER'S EVALUATION RESULTS/

1. The initial program plan shall be prepared and documented according to the time frames established by federal and/or state rules and regulations.

2. The therapist shall utilize the results of the evaluation process to prepare an occupational therapy program that is:
   a. Stated in practical outcomes applicable to the student's needs and educational goals.
   b. Consistent with principles and concepts of growth and development.
   c. Consistent with expected behavior/progress for the student's defined educational/health problems and needs.

3. The planning process shall include:
   a. Identifying short term and long term (annual) goals.
   b. Collaborating with child/family/staff to establish appropriate goals to enhance education.
   c. Participation in staffings to coordinate the occupational therapy program with the other programs within the educational setting.
   d. Documenting of practical outcomes to be achieved.
   e. Selecting the media, methods, environment and personnel to accomplish goals.
   f. Monitoring and modifying the program to meet the established goals.

4. The documented educational program plan shall consist of a statement of when these services will be provided and how long they will last.

5. When occupational therapy program goal is to prevent or diminish dysfunction in occupational performance and learning or to enhance occupational performance, the program plan shall include the use of one or more of the following types of activities:
   a. Self-care activities; may also include instruction in the use of adapted methods and/or equipment, energy conservation, joint protection techniques.

b. Home-work-shool activities; may also include instruction in the use of adapted methods and/or equipment.

c. Pre-vocational/vocational activities/skills may also include improvement of standing or sitting tolerance, general endurance, or awareness and utilization of community resources.

d. Developmental play/leisure activities; may also include instruction of family in activities appropriate for student's developmental level; instruction in the use of adapted methods and/or equipment.

6. When the goal is to prevent or diminish neuromuscular dysfunction or enhance neuromuscular development and learning, the program plan shall include, but need not be limited to, the use of one or more of the following types of activities:

   a. Activities which maintain or increase range of motion and/or muscle strength.

   b. Activities which facilitate integration of developmentally appropriate reflex/reaction behavior.

   c. Activities which provide appropriate sensory stimulation.

   d. Activities which promote the development of normal postural tone, movement patterns and motor control.

   e. Instruction in the use of proper positioning and handling techniques.

   f. Provision of and instruction in the use of adaptive equipment.

   g. Fabrication/recommendation of splints or orthotic devices/equipment.

7. When the goal is to prevent or diminish sensory integrative dysfunction or to enhance sensory integrative development, the program plan shall include, but need not be limited to, the appropriate use of:

   a. Sensory facilitation and/or inhibition techniques for vestibular, tactile, proprioceptive/kinesthetic, visual, auditory, gustatory and olfactory stimulation.

   b. Activities to promote adaptive sensori-motor response.

8. When the interdisciplinary educational evaluation results indicate goals to prevent or diminish psychological or social dysfunction, or enhance psychological or social development, the occupational therapy program shall include, but need not be limited to, the appropriate use of activities which assist the student in learning to:

   a. Experience and cope with competition, frustration, success and failure.

   b. Identify and respond appropriately to feelings.

   c. Develop or refine self-esteem or self-identity.

   d. Imitate and develop appropriate social behaviors.

   e. Listen and communicate.

   f. Develop sensitivity to other persons' feelings and behaviors. (interpersonal relationships)

9. When the interdisciplinary education team evaluation results indicate goals to prevent or diminish cognitive dysfunction or to enhance development in the cognitive areas, the occupational therapy program shall include, but need not be limited to, the appropriate use of activities which assist the student in developing:

   a. Concentration/attention span.

   b. Memory/recall.

   c. Decision making and/or problem solving.

   The purposes of the occupational therapy program in the above stated areas, (#8 and #9), are not intended to replace academic or other programming. The purposes are to assist the child to receive maximum benefit from educational programming.

Standard V: Program Implementation

THE THERAPIST SHALL IMPLEMENT THE PROGRAM ACCORDING TO THE PROGRAM PLAN.

*1. The therapist shall periodically and on an ongoing basis document the occupational therapy services provided (including techniques utilized and the results) and the frequency of the services.

*2. The therapist shall periodically re-evaluate and document the changes in the student's occupational performance and performance components.

3. The therapist shall formulate, document and implement program changes consistent with changes in the student's occupational performance and performance components.

Standard VI: Re-Evaluation

THE THERAPIST SHALL RE-EVALUATE THE STUDENT RECEIVING OCCUPATIONAL THERAPY ON A YEARLY BASIS.

*1. The re-evaluation results shall be documented.

2. If the client needs further services, the therapist shall make appropriate recommendations.

3. A re-evaluation does not necessarily constitute a referral for services.

Standard VII: Termination of Services

THE THERAPIST SHALL PREPARE AND DOCUMENT THE OCCUPATIONAL THERAPY DISCHARGE PLAN.

1. The discharge plan shall be consistent with the student's goals, functional abilities and deficits, expected prognosis and the goals of the educational planners. Consideration should be given to appropriate community resources for referral and environmental factors/barriers that may need modification.

2. The discharge plan shall be consistent with the discharge plans of the other educational planners and appropriately documented through the individual educational planning process.

3. The therapist shall document the comparison of the initial state of function abilities and deficits in occupational performance and performance components and the current state of these abilities and deficits at the time of discharge.
4. The therapist shall terminate occupational therapy services when the student has achieved the goals, or has achieved maximum benefits from occupational therapy.
5. Recommendations for follow-up or re-evaluation, if appropriate, shall be documented.

## INDIRECT SERVICES

With the provision of indirect services the occupational therapist in a school-based program performs supervision, consultation and administration/management roles.

### Standard VIII: Administration/Management

THE OCCUPATIONAL THERAPIST SHALL PROVIDE APPROPRIATE MANAGEMENT AND ADMINISTRATIVE SERVICES.

The management and administrative functions for the school-based therapist shall include:

1. Supervision of other personnel as assigned.
    a. Informal and formal training of personnel and volunteers assigned to occupational therapy.
    b. Reviewing performances (self and others) and providing evaluations.
2. Design of the occupational therapy program with periodic reviews of all aspects of the total occupational therapy program to determine its effectiveness and efficiency.
3. Occupational therapists shall systematically review the quality, including outcomes, of services delivered, using predetermined criteria reflecting professional concensus and recent developments in research and theory.
    a. To determine if actual service may be justified by peer review.
    b. If justification by peer review fails, a program to improve services shall be planned and implemented.
    c. Review will be repeated to assess the success of the corrective action.
4. Maintaining current certification as required by state regulations and AOTA.
5. Maintaining current records and files to meet school requirements and professional standards.
6. Participating in budget planning and is responsible for budget implementation.
7. Responsibility for knowledge, including use of, and utilizing community resources.
8. The therapist shall maintain and update professional knowledge and skills and seek consultation/supervision from others when necessary to assure continued competency.

Standard IX: Consultation

THE THERAPIST SHALL PROVIDE CONSULTATION SERVICES WHEN APPROPRIATE.

In the consultation role, the therapist is one member of an interdisciplinary educational team collaborating with a variety of professional personnel to assist students with special needs. The practice of consultation shall include when appropriate:

1. Developing and coordinating occupational therapy programs with the total educational curriculum.
2. Provide consultation for classroom environmental adaptation to enhance the learning potential of students.
3. Provide consultation to teachers and staff regarding the identified special needs of students.
4. Collaborate with the educational team regarding the student's program including the IEP (Individualized Educational Program).
5. Provide inservice education.
6. Provide consultation for appropriate programs outside the school program.
7. Provide consultation and education to parents to help them understand the special needs of their child.
8. Provide consultation for home environmental adaptation to enhance independent functioning.
9. Provide consultation to school administrators and staff regarding preventive health education and activities to enhance the educational environment and learning potential of students.

Standard X: Legal/Ethical Components

THE OCCUPATIONAL THERAPIST SHALL PROVIDE ALL ASPECTS OF DIRECT AND INDIRECT SERVICES ACCORDING TO LEGAL REGULATIONS AND ETHICAL STANDARDS.

1. The occupational therapist shall practice and manage occupational therapy programs as defined by federal and state laws or legal principles as they apply to issues or situations when relevant to students or themselves in school systems.
2. The therapist shall observe the ethical practices as defined by the American Occupational Therapy Association Standards and Ethics Commission.
3. The therapist should be familiar with and abide by the ethical practices of the specific school district or system in which the therapist serves.

# COMPARISON OF AOTA GUIDELINES WITH HCDE PRACTICE

Listed below is information which may clarify how procedures and guidelines of HCDE may vary from AOTA Standards of Practice for Occupational Therapy in schools. These items refer to those parts of the Standards of Practice identified with an asterisk (*).

II. 4. Some school districts require a physician's referral and parent consent prior to evaluation and/or treatment by the occupational therapist.

III. 3. If the results of the occupational therapy evaluation indicate deficits in psychological/social, cognitive, physical/medical, speech/language areas, the HCDE therapist informs the appropriate district personnel of the students deficit areas instead of directly referring the student for those services or consultation.

V. 1. Therapists document occupational therapy service provided (techniques utilized and results) and the frequency of services through completion of an ARD summary. The student's ability to function in the educational setting is also identified through the Functional School Screening (See Section II page 46) which is included in the ARD summary. (See Section II page 149).

2. A student's performance is evaluated informally every 60 days by the update of short-term objectives of the ARD-IEP. (See Section II page 148)

VI. 1. Student performance is re-evaluated on a formal basis once every three years by means of a thorough re-evaluation. (See Section II page 162).

ADOPTED BY TEXAS CHAPTER MEMBERSHIP, MAY, 1979

# GUIDELINES FOR DELIVERY OF PHYSICAL THERAPY SERVICES IN EDUCATIONAL SETTING

## I. INTRODUCTION

The "right to a free appropriate public education which emphasizes special education and related services designed to meet their unique needs" has been assured to all handicapped children by the enactment of Public Law 93-112, Section 5 of the Rehabilitative Act, and Public Law 94-142. Education for all Handicapped Children. The unique instructional and physical needs of handicapped children may interfere with the total educational process. The physical therapist, with skill and knowledge acquired through specialized and extended education, can assist in the identification and management of these unique problems that interfere with optimal learning. The mutual transfer of information between the physical therapist and the educator can provide a learning environment that enables the child to develop to his maximal learning potential in the educational setting.

## II. PURPOSE

The objectives of these guidelines are to identify:

A. Physical therapy services

B. Qualifications and requirements for delivery of services

C. Methods of acquiring services

D. Administrative concerns

E. Mechanism for assuring quality assurance

## III. PHYSICAL THERAPY SERVICES

### A. Definition

Physical therapy is a health profession which provides screening, evaluation, and integrated motor programming to develop or restore neuromuscular; musculoskeletal, cardiopulmonary, or sensory motor integrative functions to assist the student in achieving maximal performance in his educational setting. The PHYSICAL THERAPIST consults and coordinates with educational staff, other related services, personnel, parents, and community services personnel to assist in the development and implementation of the student's individualized educational programs. The PHYSICAL THERAPIST ASSISTANT functions under the directions of and acts as an assistant to the physical therapist in administering physical treatment regimes.

B. Philosophy

In contrast to the usual practice of providing physical therapy in a separate physical therapy setting, physical therapists in educational environments should utilize the classroom setting whenever possible as a therapeutic environment in order to insure that functional usefulness of skills being taught and the generalization of skills to the environments in which they are needed. The physical therapists providing services in educational environments should facilitate coordination of students' school physical therapy programs with their existing community physical therapy programs to assure total programming and avoid duplication of services.

C. Types of Services

1. Identification and Screening
    a. Reviews student's medical and educational records
    b. Administers appropriate screening tool, i.e., posture and gait analysis, developmental milestones, sensory motor integrative mechanisms
    c. Determines need for complete physical therapy evaluation and/or referral to central admission, review, and dismissal committee
2. Evaluation and Recommendations
    a. Confers with student's community physicians to determine medical needs and limitations and acquires medical referral
    b. Administers tests to determine baselines for
        1. Developmental reflex and motor skills
        2. Sensory motor integrative mechanisms
        3. Posture and gait
        4. Muscle strength, tone, and joint range of motion
        5. Cardiopulmonary function
        6. Personal independence
        7. Orthotic and prosthetic utilization
        8. Adaptive equipment utilization
    c. Records and interprets findings
    d. Makes recommendations to admission, review, and dismissal committee
3. Program Design, Planning and Implementation
    a. Designs students' individual educational programs in collaboration with educational staff, other related services personnel, parents, and community services personnel

   - b. Provides for program implementation by direct treatment and/or by training classroom staff, parents, or other child services providers to be supplementary to primary implementors
   - c. Acquires, constructs, or adapts specialized equipment to facilitate programming
   - d. Utilizes community resources whenever possible to enhance student programming

4. Re-evaluation for Continuation, Cessation, or Revision of Programming
5. Consultation
   - a. In-Service Education
     1. Interpretation of students' dysfunctions, potential for change, programming rationale, and expected outcomes.
     2. Instruction in the handling and positioning of students'; use of adaptive and assistive devices; use and care of support, bracing, orthotic or prosthetic devices; implementation of the therapeutic programs as they relate to the students' function within their educational environment.
   - b. Campus Planning
     1. Development of a functional, cost effective barrier free environment.
     2. Utilization and acquisition of special equipment.
   - c. Community Integration
     1. Identifies to the community needs of the handicapped student.
     2. Facilitates students' integration into the community.
6. Administrative Services
   - a. Establishes policies, procedures, and forms for program implementation
   - b. Supervises physical therapy programs and personnel
   - c. Plans department budget
   - d. Recruits staff
   - e. Screens applicants

7. Clinical Education
    a. Initiates, plans, and supervises on-site training for physical therapy students and assistants.
    b. Evaluates performance of students.
8. Quality Assurance

    Development of or acquisition of a peer review mechanism to assess and promote professional competencies.

## IV. QUALIFICATIONS AND REQUIREMENTS FOR DELIVERY OF SERVICES

### A. Requirements

1. Physical therapy services must be initiated and supervised by a physical therapist who has met state requirements for the practice of the profession:*
    a. Acquisition of a bachelor's or master's degree in physical therapy or a bachelor's degree and a certificate in physical therapy from a program accredited by the American Physical Therapy Association.
    b. Acquisition and maintenance of a current license issued by the Texas State Board of Physical Therapy Examiners.
    c. Acquisition of a medical referral on each student prior to initiation of treatment; referrals may be obtained through:
        1. The student's private physician
        2. The school's medical consultant
        3. A standard inclusion in each student's pre-enrollment physical examination
2. Physical therapist assistant services are provided by a technically trained individual who:
    a. Maintains a current license issued by the Texas State Board of Physical Therapy Examiners and functions under the direction of a physical therapist.
    b. Has completed a two year program in a school accredited by the American Physical Therapy Association.

### B. Qualifications - Desirable but not mandatory qualities include:

1. Several years work experience in physical therapy with one or more years in pediatric or multi-disciplinary settings.
2. Participation in continuing education related to children with special education needs.
3. Membership in the American Physical Therapy Association.

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*These are the current requirements to practice. This does not include requirements for those therapists who are foreign trained or are licensed under the Grandfather Clause. For further information on requirements for those persons, contact the Texas State Board for Physical Therapy Examiners.

## V. METHODS OF ACQUIRING SERVICES

Physical Therapy services may be acquired by:

A. Direct employment of a licensed physical therapist by the educational facility.

B. Contractual arrangements for individual students with a service delivery agency, a facility that maintains a physical therapy staff, or an individual licensed physical therapist.

## VI. ADMINISTRATIVE CONSIDERATIONS

(Administrative concerns are identified with regard to the incorporation of physical therapy services in the school system)

### A. Budgetary Considerations

1. Salaries or contractual arrangements should be based on a scale competitive with peer community salaries and reflect training qualifications and full credit for professional experience. Mileage per diem, professional liability insurance, vacation, sick leave, health insurance, and retirement should be taken into consideration.

2. Appropriations for physical therapy documentation records and equipment for program implementation should be allocated.

### B. Conditions of Employment

With regard to the practice of the profession, physical therapists must be regulated by their own governing bodies as it concerns professional supervision, collective bargaining, educational preparation and continuing education requirements.

### C. Long Range Planning

The concept of physical therapy in the school system is new. As long range administrative goals are developed and effected, it should be recognized that physical therapists should contribute to that planning. The expertise that physical therapists have, can be of assistance to administration in such areas as future building projects, mainstreaming, space, and equipment needs, etc. It further assures that long range physical therapy goals are in step with administrative and educational planning.

### D. Space Requirements

Space requirement should be considered prior to implementation of physical therapy services. Space allocations will vary and be dependent on the nature and intensity of services acquired by the school. Physical therapists should be included in this kind of planning. Consideration for space requirements should include areas for documentation and recording.

E. Secretarial Support

Consideration should be given to secretarial support as well as other supportive services such as telephones. Communication, both oral and written, with physicians, parents, educators, and other professionals, and documentation are essential. Adequate secretarial support to assist in routine typing, filing, etc., will free the physical therapist to perform professional responsibilities.

F. Physical Therapist/Child Ratios

These ratios will be dependent on:

1. Nature and intensity of services provided
2. Variety and concentration of diagnosis and degree of handicapping situations
3. Location and population of area being served

## VII. SUMMARY

The assurance that all handicapped children in the State of Texas receive appropriate educational services consisting of special education and related services which include physical therapy is a reality. Physical therapists, by nature of their specialized education and training, can contribute to the total planning and assist in the implementation of a statewide program. The presence of physical therapy representation in formal planning sessions can provide unparalleled expertise. It is suggested the consideration be given to the placement of a physical therapist consultant in a state advisory capacity, either by serving on an advisory board or by an appointment within the Texas Education Agency. Such an individual should demonstrate evidence of knowledge and/or experience in administration, general education, psychology, child growth and development.

## VIII. ADDENDUM

The responsibility of providing services for children ages, birth to three has not yet been mandated to the public schools, nor has it been generally accepted that the provision of these services lies within the realm of public education. The special needs of children of this age category deserve much consideration so that the necessary deviations from a typical educational model can be realized and incorporated. The diagnosis, prognosis, and program needs are often not clearly established for a child age birth to three. Physicians and other health professional must, therefore, be actively involved in programming for these children. Regardless of which agency provides the services, there are several important considerations which must be applied to birth through three.

A. The program must provide for equal emphasis to be placed on the child's medical, therapeutic, and educational needs.

B. The program must provide adequate medical support.

C. The program must provide for the services of competent health professionals such as physical therapists, speech pathologists, audiologists, psychologists, medical social workers, etc. as well as competent educators.

D. The program approach must facilitate development of good parent/child relationships.

# MODES OF SERVICE IN THE EDUCATIONAL SETTING

There are three modes of service delivery within a school-oriented OT/PT program. They are modes of assessment, intervention, and program planning. (Forms and Procedures are found in Section II.)

| I. Assessment | II. Intervention | III. Program Planning |
|---|---|---|
| A. Screening<br>B. Indepth Evaluation | A. Hands-On Therapy<br>B. Consultation<br>1. Student-Centered<br>2. Teacher-Centered<br>3. Program-Centered | A. Purpose<br>B. Planning Activities<br>1. Student-Oriented<br>2. Teacher-Oriented<br>3. Program Oriented |

I. Assessment

A. Screening

1. Purpose:
    a. To determine the functional level of the student in the school setting.
    b. To identify deficit areas requiring indepth evaluation.
    c. To provide a framework for recommendations by coordinating the teacher's goal with the student's functional level.
    d. To serve as a baseline for future re-evaluations.
2. A screening is performed on all newly referred students and on those students who are being reviewed for the Annual ARD or for a three-year re-evaluation.
3. Completion of the screening involves observation of the student and a meeting of the teachers and therapist to discuss the student's level of function in the school setting and the teacher's long term goals for the student.

B. Indepth Evaluation

1. Purpose: To provide a comprehensive assessment and documentation of the student's functional deficits previously identified in the screening process.
2. Students who display functional deficits (dependent/requiring assistance) during the screening process, receive indepth evaluation of the deficit areas.
3. Types of indepth evaluations
    a. Motor development
    b. Self-help
    c. Clinical

d. Sensory integration

e. Pre-vocational

4. An educationally oriented summary of evaluation results, data, and recommendations regarding therapy services is prepared by the therapist in an evaluation report.

II. Intervention

A. Consultation

1. Purpose: To provide professional advice to the disciplinary team or any member thereof for the coordination of services. This involves multiple communications and demonstrations.

2. Types of consultation:

a. Student centered when

1) Student's needs can be met by a modification within the classroom.

2) Therapist demonstrates with the child the techniques to be utilized.

3) Follow-up observation and perhaps modification would be necessary.

b. Teacher centered when

1) Problems are more generalized and not specific to one child.

2) Teacher's needs are specified.

3) Solutions are discussed and tried.

4) Recurrent follow-up may or may not be necessary.

c. Program centered when

1) Developing or expanding a program.

2) Modifying curriculum to meet the needs of a specific group of children.

3) The teacher and/or aide implement the program on a daily or bi-daily basis.

4) The therapist monitors the program on a weekly, bi-weekly or monthly basis.

5) The therapist gives input for updating or refining program.

3. Variables which may assist in determining most appropriate type(s) of consultation
    a. Functional problem of the child.
    b. Level of expertise of the teacher and classroom help.
    c. Curriculum philosophy of the district.
    d. Expectactions of the teacher.
4. Consultation services may include
    a. Instruction in use and care of adaptive equipment, assistive devices, and splints.
    b. Organization of group programs to be carried out by teaching staff with input from therapist.
    c. ARD attendance
    d. Conferences with parents, teachers, etc.
    e. Presentation of inservices
    f. Consultation with school personnel concerning architectural adaptations.

III. Program Planning

A. Purpose: To expedite a coordinated and functional program.

B. Planning Activities

1. Student oriented planning may include
    a. Report writing.
    b. Writing and updating IEP's.
    c. Treatment planning.
    d. Writing home programs and DAP's.
    e. Fabricating adaptive equipment, assistive devices, and splints.
2. Teacher oriented planning may include
    a. Planning inservices.
    b. Writing school program DAP's and motor lab programs.
    c. Preparing for teacher/classroom consultation.
3. Program oriented planning may include
    a. Maintaining equipment.
    b. Inventorying equipment and materials.
    c. Requisitioning equipment and materials.
    d. Continuing education.

e. Tracking student referrals for evaluation.
f. Tracking teachers' request for consultation.
g. Tracking student data.

## CASELOAD RECOMMENDATIONS

The ratio of students to therapist should be established according to individual student and district needs. The optimum ratio per therapist varies depending on the following factors:

1. Range and severity of handicap (See example D1)
2. Modes of service provided (See example D2)
    a. Consultation
    b. Hands-on therapy
3. Scheduling factors (See example D3, 4, 5, 6.)
    a. Meals
    b. School activities
    c. Age of children
    d. Length of school day
    e. Transportation
4. Availability of aides or additional personnel.
5. Length of professional day.
6. Availability of treatment space, equipment, room structure and location.
7. Other support services being provided.
8. Geographical area and amount of travel.
9. Time allotment for therapist must take into consideration their total role in the school system. Time may be allowed for
    a. Evaluation
    b. Home visits
    c. Documentation
    d. Parent consultations
    e. Research efforts
    f. Providing and receiving in-service
    g. Continuing education and professional development
    h. Design of adaptive devices
    i. Preparation of IEP's
    j. Progress and program reports
    k. Participation in ARD meetings
    l. Observation of student performance in classroom and other support service programs where needed.[1,2]

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1. "Guidelines for Occupational and Physical Therapy Services in the Public Schools of Virginia" August, 1978 VA Dept. of Education.
2. Occupational Therapy in the School Systems: "Information Packet", American Occupational Therapy Association, Rockville, MD, 1979

Example D1

## DEFINITIONS PERTAINING TO CASELOAD DATA FOR OTs and PTs[3]

### Severe Handicap

1. No head control, no sustained head control.
2. Presence of and/or potential for deformities which are functionally limiting or pain producing.
3. Presence of perceptual and/or sensory-integrative deficits which prevent the achievement of academic skills and age level motor skills.
4. Total dependence with regard to physical needs.

### Moderate Handicap

1. Functional head control.
2. Presence of perceptual and/or sensory-integrative deficits which interfere with the achievement of academic skills and age-level motor skills.
3. Some independence with regard to physical needs.

### Mild Handicap

1. Potential to improve quality of motor and/or perceptual skills with therapy intervention.
2. Potential for regression in quality of motor and perceptual skills without intervention.
3. Independence with regard to physical needs.

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[3] Doris Taylor, OTR Issaquah School District, Issaquah, Washington.

## MODELS FOR DELIVERY OF OT/PT SERVICES[4]

| Model | Expected Caseload for Direct and Consultative Services | |
|---|---|---|
| 1. Center-based: Services to children located in geographical proximity-may be categorical - services delivered at a specific site. A therapist may serve more than one site. | Direct Therapy: | Not more than 12-16 clients per week with an average treatment of 1/2 hour two times per week.* |
| | Consultation: | Approximately 40-60 clients including those in direct therapy.* |
| 2. Itinerant or Resource: Services to children in a variety of settings, (e.g., regular classrooms where therapist travel). | Direct Therapy: | Not more than 10-12 clients per week wi[illegible] an average treatment of 1/2 hour two times per week. |
| | Consultation: | Approximately 30-50 clients including those in direct therapy. |
| 3. Contracted: Services purchased for specific children. | Dependent upon contract. | |

*If students are on site for less time than usual school day (e.g., some pre-school programs), 10 direct service students is a maximal caseload out of a total consultative group of 30-50.

4. "Guidelines for Occupational and Physical Therapy in the Public Schools of Virginia" August, 1978 VA Dept. of Education.

## REFERRAL PROCESS FOR OT/PT EVALUATION

Although each district has its own procedure for referring children, the basic referral process is the same. This includes the following:

1. A child may be referred for OT/PT evaluation by a parent or a member of the educational staff within the school. Consultation by an OT/PT may precede a referral for evaluation.
2. There must be an educational reason for referral.
3. A parent consent form must be filled out on every child for OT/PT evaluations.
4. Signed physician referral forms are required prior to all PT evaluations. Some districts require OT physician referrals.
5. When forms have been completed and returned to the school, the child's name will be placed on a tracking sheet ready for evaluation.

Three districts in Harris County have been chosen to give a sampling of the referral process in a rural, suburban and urban population. (See Section III.)

## EVALUATION PROCESS

1. When the prescribed forms have been given to the OT/PT, the evaluation will be administered to determine the need for educationally relevant intervention. Recommendations will be made accordingly.
2. When the evaluation has been completed, the report is written and submitted to HCDE for professional review and tracking. It is then typed and sent to the district.

# ARD/IEP PROCESS

(This information is based on TEA Guidelines.)

1. Purpose of the ARD Process
    a. To determine a student's eligibility for special education and related services by reviewing reports of assessments.
    b. To develop an IEP.
    c. To recommend an appropriate placement in which the student's educational needs may be met.
2. ARD Committee Membership
    a. At least 3 members who represent administration, instruction, and assessment (one must be from special education).
    b. An education liaison.
    c. The parent (a meeting may be held without the parent if the district is unable to convince the parent to attend).
    d. The student, when appropriate.
3. Functions of the Committee
    a. Review instruction program quarterly - "Update or Three Month Review".
    b. Review placement annually.
    c. Review eligibility comprehensively at least once every three years.
    d. Approve any major change in the student's program (e.g., long term goals or amount of therapy time).
4. Duties of the OT/PT in the ARD/IEP Meeting (In some districts, the OT/PT does not attend).
    a. Share the findings of the student's present level of functioning based on evaluations and observations.
    b. Make OT/PT recommendations to the committee.
    c. Present long-term goals that are based on documented educational problems and physician's recommendations when indicated. These goals reflect a broad statement for the year.
    d. When developing the IEP, formulate short-term objectives that work toward achieving the long-term goals. These should be measurable behaviors that can be achieved and reviewed within 60 days.
    e. When the goals have been established by the ARD/IEP Committee, the therapist will recommend frequency and mode(s) of service to be offered (e.g., hands-on, consultation).

5. The ARD/IEP should include
   a. A statement of the student's present competencies.
   b. A statement of annual goals and short-term objectives.
   c. A statement of specific services provided for the student.
   d. A statement of the amount of time spent and dates of initiating services.
   e. A statement of criteria for evaluating short-term objectives.
   f. Signatures of the committee.

6. ARD Follow-Up Procedure
   a. Provided the ARD/IEP Committee approves the therapist's recommendations (and the necessary physicians referral is on file), therapy can begin as soon as a schedule is arranged with the teacher and therapist.
   b. When therapy services are provided, the therapist should receive a copy of the IEP.
   c. All IEPs will be updated according to the TEA guidelines.

7. Three-Year Review
   a. Every three years after placement, the professionals responsible for assessment shall determine and document the degree to which new assessments in each area are necessary.
   b. If no new assessments are necessary, each general area of the student's functioning is assessed.

## ENVIRONMENTAL FACTORS

1. Advantages of a designated treatment area
    a. Provides privacy for student being treated.
    b. Allows for utilization of specific equipment and materials sometimes not available in the classroom (e.g., vestibular boards, scooter boards, mats).
    c. Provides more space for gross motor activities (e.g., running, tumbling, scooter board activities, balance beam).
    d. Saves therapist time in transporting and setting up equipment.
    e. Provides a structured environment free from environmental distraction.
    f. Prevents distractions to other students in the classroom.
2. Advantages of classroom treatment
    a. Provides an opportunity to establish rapport with teachers and aides.
    b. Enables the therapist to realistically assess the student's performance in classroom activities.
    c. Facilitates therapist's ability to write practical, educationally relevant therapy goals.
    d. Provides an opportunity to access and/or utilize resources in the classroom.
    e. Saves the therapist time in moving the student from "class environment" to "therapy environment".
    f. Insures continuity of service for the student by providing the teacher with a role model and guidance in an on-going individualized program.
    g. Decreases the amount of interruption in the student's school day.

# EQUIPMENT RECOMMENDATIONS

The following recommendations are made for a district beginning their program and having one occupational therapist and one physical therapist.

In order for the OT/PT to perform adequately, it is essential that funds be provided for the purchase of basic equipment and for the maintenance of this equipment. The following is a list of suggested items:

Most-Suggested

- mats
- bolsters
- wedges
- safety belts
- mirror
- prone stander
- scooter boards
- toys (manipulative)
- balls
- wheelchair tray
- A.D.L. equipment and aids
- vestibular ball
- inner tubes

Suggested

- exercise equipment
- standing tables
- wheelchairs
- vibrator
- splinting material
- heat gun
- electric skillet
- balance beam
- trampoline
- adaptive seating

At this writing, the expected initial cost of the equipment in the "most-suggested list should be a minimum of $1000. In addition, funds should be allotted for expendable items such as splinting materials, webbing, velcro, and various shop supplies. Suggested yearly budgetary allotment for expendables should be a minimum of $150 per therapist. Some low-cost adaptive equipment may be developed by carpenters and carpentry support (e.g., high school workshop, parent workshop, janitor/maintenance staff, retired handy men). These items should also be included in the budget.

In addition to equipment and materials, the budget should include money for standardized tests and assessment tools in such areas as motor development, visual-perception, and pre-vocation.

# SUPERVISORY SUPPORT

1. Field Observation
   A. PURPOSE
      1. To document the therapist's strengths and weaknesses as identified by the assistant coordinator or program assistant upon observation of the therapist during the performance of his/her job.
      2. To provide objective information to administration for assistance in completing therapists' annual performance appraisals.
      3. To provide constructive feedback to therapists concerning job performance.
      4. To identify personnel with expertise so that they may be used as resource persons for other therapists.
      5. To provide therapists with an opportunity to express their feelings and philosophies.
      6. To facilitate good public relations between HCDE and district school administrators.
      7. To allow therapists to get a feel for what is expected of a staff person at HCDE.
      8. To provide administrators with a basis for writing a deficiency plan when necessary.

   B. UTILIZATION
      1. This form will be filled out on every therapist at least once during the school year.
      2. Multiple visits are recorded on the same form (color coded) and occur at the discretion of the administration. Reasons for multiple field observations include:
         a. Therapist's change of setting.
         b. Therapist's lack of expertise in specific areas.
         c. Therapist's request.
         d. Change in performance noted in other areas of work (e.g., paperwork).
      3. The report is filled out by the assistant coordinator or program assistant after a minimum two-hour visit. Observations are discussed and agreed upon by both the program assistant and therapist and signed by both parties.
      4. The report is submitted to the coordinator for review to become part of HCDE personnel file.

2. Performance Appraisal

   A. PURPOSE

      1. To give the employee feedback regarding his/her performance in assignments.
      2. To give the employee an opportunity to discuss the past year's work performance and feelings about job assignments with administrators.
      3. To give the employee an understanding of expectations for the following year.

   B. UTILIZATION

      1. This form is completed each spring by the employee's coordinator and/or assistant coordinator.
      2. Information from this form may be used in considering an employee for re-assignment.
      3. With the employee's permission, information from this form may be used when recommending the employee for other job settings.
      4. The information recorded on this form will be used to develop the employee's individual goals for the following year.
      5. The form becomes part of the employee's HCDE official personnel file.

# RESOURCES

## 1. LOCAL ORGANIZATIONS (Harris County Area)

| | |
|---|---|
| Assoc. for Education of Physically Handicapped Children | 713-723-2878 |
| Assoc. for Retarded Citizens | 713-527-9055 |
| Boy Scouts of American Scouting for the Handicapped | 713-659-8111 |
| Can-Do-It | 713-522-5228 |
| Children's Resource and Information Service* | 713-526-8597 |
| Cleft Palate Parent Society | 713-353-7335 |
| Coalition for Barrier Free Living | 712-526-1651 |
| Cystic Fibrosis Foundation | 713-627-1060 |
| Easter Seal Society for Crippled Children Harris County | 713-526-1651 |
| Feingold Association of Houston | 713-780-3979 |
| Governor's Coordinating Office for Visually Handicapped | 1-800-252-9211 |
| Gulf Coast Council for Exceptional Children | 713-691-4521 |
| Houston Area Assoc. for Communication Disorders | 713-795-4460 |
| Houston Area Parents of Hearing Impaired | 713-774-0808 |
| Houston Assoc. for Retarded Citizens | 713-527-9055 |
| Houston Central Lions Club | 713-227-5466 |
| Houston Coordinating Council for the Handicapped | 713-222-1121 |
| Houston Council for Youth Development | 713-464-3413 |
| Lutheran Social Services of Texas | 713-445-1544 |
| Leukemia Society of America-Gulf Coast Chapter | 713-529-8709 |
| Mental Health Association of Houston and Harris County | 713-522-5161 |
| Mentally Retarded Teens | 713-729-3200 |
| Metro-Houston March of Dimes | 713-665-5555 |
| Mothers Against Dystrophy | 713-468-1375 |
| Muscular Dystrophy Association of America | 713-961-1941 |
| National Society of Autistic Children | 713-682-4494 |
| Parents Anonymous | 713-228-1505 |
| Parents of Children with Downs' Syndrome | 713-498-7027 |
| South West Wheelchair Athletic Association | 713-749-1528 |
| Spina Bifida Association | 713-862-1446 |
| Texas Child Care | 713-772-3752 |
| Texas Society for the Prevention of Blindness | 713-526-2559 |
| United Cerebral Palsy of Gulf Coast | 713-461-=6269 |

*See Comprehensive List, Page . 46

## 2. NATIONAL ORGANIZATIONS

| | |
|---|---|
| Superintendent of Documents, U.S. Government Printing Office<br>Washington, DC 20402 | |
| American Assoc. for the Education of the Severely/Profoundly Handicapped<br>P.O. Box 15287<br>Seattle, Washington 98115 | 206-543-4011 |
| American Foundation for the Blind, Inc.<br>15 West 16th Street<br>New York, New York 10011 | 212-924-0420 |
| American Printing House for the Blind<br>1839 Frankfort Avenue<br>Louisville, Kentucky 40206 | 502-895-2405 |
| Assoc. for Children with Learning Disabilities<br>5225 Grace Street<br>Pittsburg, Pennsylvania 15236 | 412-881-1191 |
| Boy Scouts of American Scouting for the Handicapped<br>U. S. Route 1 and 130<br>North Brunswick, New Jersey 08902 | 201-249-6000 |
| Center for Innovation in Teaching the Handicapped<br>University of Indiana<br>2805 East Tenth Street<br>Bloomington, Indiana 47401 | 812-337-5847 |
| Council for Exceptional Children<br>CEC Information Services<br>1920 Association Drive<br>Reston, Virginia 22091 | 703-620-3660 |
| Curriculum Research and Development Center in Mental Retardation<br>Yeshivia University<br>55 Fifth Avenue, Room 1409<br>New York, New York 10003 | 212-255-5600 |
| Cystic Fibrosis Foundation<br>3379 Peachtree Road, N.E.<br>Atlanta, Georgia 30326 | 404-262-1100 |
| Down's Syndrome Congress<br>20438 Renfrew Road<br>Detroit, Michigan 48221 | 313-494-5747 |
| Epilepsy Foundation of America<br>1828 L Street N.W.<br>Washington, DC 20036 | 202-293-2930 |

Helen Keller National Center for the Deaf-Blind Youths and Adults 516-944-8900
111 Middle Neck Road
Sands Point, New York 11050

Mental Disability Legal Resource Center 202-331-2240
Commission on the Mentally Disabled, American Bar Association
1800 M Street, N.W.
Washington, DC 20036

Muscular Dystrophy Association, Inc. 212-586-0808
810 Seventh Avenue
New York, New York 10019

National Association for Music Therapy 913-842-1909
P. O. Box 610
Lawrence, Kansas 66044

National Association for Retarded Citizens 817-261-4961
1709 Avenue E East
Arlington, Texas 76011

National Center for Law and the Handicapped 219-288-4751
1235 North Eddy Street
South Bend, Indiana 46617

National Easter Seal Society for Crippled Children and Adults 312-243-8400
2023 West Ogden Avenue
Chicago, Illinois 60612

National Society for Autistic Children 304-697-2638
Information and Referral Service
306 31st Street
Huntington, West Virginia 25702

Spina Bifida Association of America 608-836-8959
209 Shiloh Drive
Madison, Wisconsin 53705

United Cerebral Palsy Association, Inc 212-889-6655
66 East 34th Street
New York, New York 10016

## CRIS DATA BANK COMPREHENSIVE LIST

Children's Resource and Information Service's data bank includes in-depth information on all services for ages 0 - 21 in the Houston-Harris County area plus a large number of out-of-county and out-of-state services.

Below is a complete index of the types of services and types of presenting problems which are on file to give agencies and individuals a better idea of how CRIS may serve them.

### Service Categories

Adoption
Advocacy
Aid (clothing, financial, food, medical supplies, toys)
Audiology
Baby-sitting
Biofeedback training
Camping (day, overnight, residential, therapeutic)
Case finding and outreach
Colleges and Universities
Community Centers
Counseling (by volunteer under supervision, genetic, informal, psychotherapeutic, rape-victim)
Crisis Intervention
Cultural Enrichment
Day Care (children, therapeutic)
Dental Service
Detention
Diagnostic (educational, medical psychological)
Drug Education
Education (alternative schools, boarding schools, private day schools, public, special education, private schools)
Emergency Shelter
Family Day Homes
Family Life & Sex Education
Family Planning
Foster Care
Group Service-troop type
Halfway House
Health Care-prevention
Health Education
Home Health Aid
Homemaker Service
Hotline
Infant Stimulation
Information and Referral
Intergroup Relations
Job Placement
Law Enforcement
Legal Counseling & Representation
Library Services
Maternity Services (in-patient, outpatient)
Medical (in-patient care, in-patient psychiatric, outpatient)
Mother's Day Out
Ophthalmology Services
Optometry Services
Parent of Consumer Education
Parent Education
Personal Improvement
Physical Education and Athletics
Planning and Research-children
Pre-School Education
Professional Organization
Protective Services-children
Public Education
Recreation
Rehabilitation Therapy
Religious Education
Residential Care-custodial
Residential Treatment
Respite Care
Screening-psychological/educational
Sheltered Employment
Speaker's Bureau
Speech Pathology Services
Therapeutic Nursery
Training
Transportation
Tutoring (college, enrichment, GED remedial)
Visual Screening
Vocational Guidance, Training

# PART II

## EVALUATION SUMMARY REPORT (FACE SHEET)

ME:________________________ D.O.B.:______________ AGE:______________

SCHOOL:________________________ DISTRICT:______________ DATE TESTED:__________

REFERRED BY:________________________________________ GRADE:______________
(School Personnel) (Title)

HANDICAPPING CONDITION:________________________________________

EDUCATIONAL REASON FOR REFERRAL:________________________________________

REFERRING PHYSICIAN:________________________________________
(Name) (Address) (Phone)

CLINIC (If applicable):________________________________________
(Name) (Address) (Phone)

M.D. SPECIFIC RECOMMENDATIONS (If applicable):________________________________________

CONTRAINDICATIONS AND/OR PRECAUTIONS:________________________________________

SOURCES OF EVALUATION:

_____OT/PT Functional School Screening
_____Clinical Evaluation
_____Developmental Evaluation
_____Reflex Evaluation
_____Self-Help Evaluation
_____S.I. Evaluation
_____Other______________
_____ ______________
_____ ______________

## SUMMARY OF (OCCUPATIONAL) (PHYSICAL THERAPY) EVALUATION

SERVED BEHAVIOR AND BACKGROUND INFORMATION:

EVALUATION TIME:______________________ TESTING SITE:______________________

SUMMARY OF INTERPRETATION:

STRENGTHS

| PROBLEMS | SUGGESTED INTERVENTION |
|---|---|

RECOMMENDATIONS: (HISD should not address item # 2.)

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services are
   - _____not indicated at this time as this student is functioning adequately within the limits of his/her disabil (ity) (ities).
   - _____indicated at this time.
2. Suggested amount of time: ____________________
3. Long term goals might include: ____________________
4. A (home/school program) (directed activity program) will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

Attached are copies of individual evaluation reports.

Signature(s) /Title(s)

Date

## PROCEDURES FOR EVALUATION SUMMARY REPORT (FACE SHEET)

I. PURPOSE:

A. To give an educationally oriented summary of the evaluation data.
B. To state recommendations regarding therapy services.

II. UTILIZATION: If space provided on the Evaluation Summary Report (Face Sheet) is inadequate, use additional lined paper and paperclip it behind the Summary. DO NOT write on the back of the form.

A. Biographical Information:

1. Put last name first.
2. Specify Elementary - Elem., Junior/Senior High - Jr./Sr. Hi.
3. Date may include several testing sessions.
4. Title of referring person must be included. When in doubt of who referred student: in urban, put area associate director; in suburban districts, put referring diagnostician or supervisor.
5. Put handicapping condition according to TEA guidelines, not the diagnosis.
6. "Educational Reason for Referral" should be stated briefly and in behavioral terms (i.e., difficulty with classroom mobility and positioning).
7. Specify the type of evaluation (Occupational) (Physical Therapy) by circling the appropriate title(s).

B. Observed Behavior and Background Information:

1. Give description of student as related to function (race, sex, and age may be included here).
2. Give medical diagnosis if known.
3. Note adaptive equipment - glasses, hearing aid, electric wheelchair, etc.
4. Give the student's attitude, distractibility, work habits.
5. Complete evaluation time and testing site.

C. Summary of Interpretation:

1. Under "Strengths" list the functional abilities (as identified by the "OT/PT Functional School Screening"), as well as social relationships/behavior, motivation, and sources of support (i.e., teacher, caretaker, family environment).
2. Under "Problems" list the clinical findings (identified by the indepth evaluation(s) which result in compromised functional activities as indicated by the "OT/PT Functional School Screening" (i.e., poor muscle strength which prevents push-up for wheelchair to toilet transfer).
3. Under "Suggested Intervention" list possible solutions to the corresponding identified problems.

## II. UTILIZATION:

### D. Recommendation:

1. Complete recommendation #1 by checking the appropriate space and circle the appropriate response "his/her" and "disabil(ity) (ities)".
2. If therapy is indicated, complete the amount of time recommended.
3. If therapy is indicated, complete recommendation #3, re: long-term goals. Goals should come from the suggested intervention list. If the entire list is included, then state, "Long-term goals might include the above stated list under 'Suggested Intervention'".
4. Circle "home/school program" or "directed activity program" if one is provided. Cross through the item if a program will not be provided.
5. If the standard check-off recommendations are not appropriate and need to be revised; or if they need to be added to, please do so. Cross through the recommendation section if totally revising or complete appropriate sections and attach a sheet with new recommendations.
6. Some guidelines when making recommendations might include:
    a. A therapist should make recommendations pertaining to that student's physical needs regarding function within the school setting. It is not the prerogative of the therapist to make recommendations regarding the appropriateness of the school placement.
    b. Decisions regarding the physical placement and special education classification are the responsibility of the ARD committee and no recommendations addressing these specific areas should be made.
    c. When making recommendations re: adapted equipment, the educational relevance of the equipment must be included.
    d. Unusual recommendations being considered should be discussed verbally with the HCDE Assistant Coordinator or Program Assistant (i.e., summer program) before the report is written.
    e. Any discussion with the parents should include what the therapist can provide within the scope of the educational setting as specified by the ARD committee.
    f. When making recommendations for a home program, therapists should keep in mind the constraints of total family needs. The home program should be presented as an option which could augment the school therapy program.

## II. DISPOSITION:

A. Turn in the "Evaluation Summary Report (Face Sheet)" along with all evaluation data to your Lead Therapist. An initial evaluation should consist of the following in this order:

1. Evaluation Summary Report (Face Sheet)
2. OT/PT Functional School Screening
3. Write-up sheets for any indepth evaluations
4. Protocols from any indepth evaluations
5. Parent permission form
6. Physician referral form (when appropriate)

III. DISPOSITION:

A.
7. Teacher referral checklist (when appropriate)
8. A copy of "Notification of Completed OT/PT Evaluation"

B. The Lead Therapist will:

1. Review all information
2. Submit to the typist when approved, or return it to the therapist if corrections are indicated.

C. After typing, the student's HCDE file, including the report, will be placed in the therapist's basket for proofing and signing. Return the file to the secretary who will distribute:

1. Original and 1 copy to the school district
2. 1 copy to student's HCDE file
3. 1 copy to therapist
4. 1 copy to the physician, when appropriate

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713)692-6216 T1/8-80

PSYCHOLOGICAL SERVICES DIVISION

EVALUATION SUMMARY REPORT (FACE SHEET)

NAME: Brown, Julia D.O.B.: 7/7/75 AGE: 5·3

SCHOOL: Jensen Elementary DISTRICT: Houston - Area V DATE TESTED: 9/30/82

REFERRED BY: Loretta Wyndon (School Personnel), Nurse Consultant (Title) GRADE: ECH

HANDICAPPING CONDITION: PH, OH

EDUCATIONAL REASON FOR REFERRAL: Incoordination, clumsiness in class, difficulty in tracking/copying

REFERRING PHYSICIAN: A. G. Hogan (Name) 4501 Groveway, Houston 77087 (Address) 467-9876 (Phone)

CLINIC (If applicable): Junior League Clinic (Name), Texas Childrens Hospital Houston 77030 (Address) 791-2226 (Phone)

M.D. SPECIFIC RECOMMENDATIONS (If applicable): PT-Screening only OT-Assist utilization of right hand and leg

CONTRAINDICATIONS AND/OR PRECAUTIONS: none

SOURCES OF INFORMATION:

✓ OT/PT Functional School Screening
___ Clinical Evaluation
✓ Developmental Evaluation
✓ Reflex Evaluation
✓ Self-Help Evaluation
___ S.I. Evaluation
___ Other ___

SUMMARY OF [✓ OCCUPATIONAL] [✓ PHYSICAL THERAPY] EVALUATION

OBSERVED BEHAVIOR AND BACKGROUND INFORMATION:

Julia is a Jensen Elementary ECH student with a diagnosis of right hemiparesis as a result of a thalamic tumor which was removed at nine months of age. Julia was very cooperative and tried her best during the testing sessions. Some translation to Spanish was necessary as Julia had difficulty understanding some directions given in English. Her teacher reports that Julia's ability to communicate in Spanish is good, while her ability to speak English is limited to simple statements. Julia ambulated independently to the testing site with the use of a right short leg brace. Her teacher is working towards classroom independence.

EVALUATION TIME: 2 1/2 hours TESTING SITE: ECH classroom, bathroom

Evaluation Summary Report (Face Sheet)/2

SUMMARY OF INTERPRETATION:

STRENGTHS

1) Cheerful, cooperative attitude
2) Interacts well with classmates/teacher
3) Functions well in classroom activities and adaptive PE class.

| PROBLEMS | SUGGESTED INTERVENTION |
|---|---|
| 1. Developmental delay of 3 years 6 months in gross motor; 3 years 9 months in fine motor which may limit performance in classroom and during P.E. | 1a. Consultation to classroom teacher for fine motor activities<br>b. Directed Activity Program for parents and school<br>c. Gross motor is being met by A.P.E. |
| 2. Dependent in dressing skills requiring assistance of the teacher and teacher aide. | 2a. Consultation to classroom teacher to encourage self dressing using verbal and demonstrative assistance<br>b. Dressing activities to be included in DAP'S for home and school. |
| 3. Requires teacher or teacher aide assistance for positioning on toilet. | 3. Use of small step in bathroom with stand-by assistance by teacher's aide. |

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services are
   ____ not indicated at this time as this student is functioning adequately within the limits of his/her disabil (ity) (ities).
   ✓ indicated at this time.
2. Suggested amount of time:
3. Long term goals might include: 1. Stimulate development of fine motor skills for improved classroom participation 2. Improve dressing skills for increased independence at home and school 3. Promote use of step in bathroom for independence.
4. A (home/school program)/[✓ (directed activity program)] will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

Attached (is a/are) (copy/copies) of individual (screening/and/evaluation) report(s).

Jill Doe, OTR/ Pat Hat, LPT

Signature(s)/Title(s)

10/3/82

Date

## OT/PT FUNCTIONAL SCHOOL SCREENING

STUDENT: ____________ SCHOOL: ____________ AREA: ____________

D.O.B.: ____________ TEACHER: ____________

Level Key: D-Dependent A-Assistance S-Standby I-Independent HANDICAPPING CONDITION:

Data Source Key: O-Observed T-Teacher Report S-Student ____________
P-Parent

| | MOBILITY | SELF-HELP | POSITIONING | ADAPTIVE EQUIPMENT |
|---|---|---|---|---|
| Classroom Activities | Level: Data: | Level: Data: | Level: Data: | Level: Data: |
| Bathroom | Level: Data: | Level: Data: | Level: Data: | Level: Data: |
| Cafeteria | Level: Data | Level: Data: | Level: Data: | Level: Data: |
| Transportation: Home to school | Level: Data: | Level: Data: | Level: Data: | Level: Data: |
| Locomotion: Within School | Level: Data: | Level: Data: | Level: Data: | Level: Data: |
| Dressing | Level: Data: | Level: Data: | Level: Data: | Level: Data: |
| P.E./A.P.E. | Level: Data: | Level: Data: | Level: Data: | Level: Data: |

Teacher's Long-Term Goals

1. ____________
2. ____________
3. ____________
4. ____________

Signature/Title ____________ Date ____________

## OT/PT FUNCTIONAL SCHOOL SCREENING

STUDIENT: ______________________ SCHOOL: ______________ AREA: ______

D.O.B.: ______________________ TEACHER: ______________________

Level Key: D-Dependent A-Assistance S-Standby I-Independent HANDICAPPING CONDITION:

Data Source Key: O-Observed T-Teacher Report S-Student
P-Parent

______________________

| | Mobility (include to and from) | Self-Help | Positioning/ Adaptive Equipment |
|---|---|---|---|
| Classroom Activities | | | |
| Bathroom/ Dressing | | | |
| Cafeteria/ Feeding | | | |
| PE/APE | | | |

Related Info: (Vision, Communication, Auditory, Transportation) ______________________

______________________

______________________

Teacher's Long-Term Goals

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Signature/Title ______________________

Date ______________________

# PROCEDURES FOR OT/PT FUNCTIONAL SCHOOL SCREENING

## I. PURPOSE:

A. To look at the functional level of the student in the school setting.
B. To identify areas which need indepth evaluation.
C. To provide a framework for recommendations by coordinating teacher's goals with student's functional level.
D. To serve as a data base for future re-evaluations.

## II. UTILIZATION:

A. This form will be used for:

1. All newly referred students.
2. All students being reviewed for the annual "ARD Summary Report".

B. With newly referred students, only the therapist assigned to contact the student and teacher should complete the "Functional School Screening". Upon completion, an NCR copy should be given to the assigned co-therapist.

C. Each catagory should have the level and data source code indicated in the appropriate place.

D. The "Level Key" indicates that amount of assistance required by the student and should be listed by letter code, e.g., "D".
D-Dependent, indicates total dependence.
A-Assistance, indicates any level of assistance required by another person.
S-Standby, indicates verbal prompting and standby supervision for safety.
I-Independent, indicates total independence. Functional within time and safety limits.

E. The "Data Source Key" indicates how the information was obtained and should be listed by letter code, e.g., "O"
O-Observed, indicates observation by the therapist.
T-Teacher report, indicates activities not observed by the therapist but reported on by the teacher.
S-Student report, indicates activities not observed by the therapist but reported on by the student.
P-Parent report, indicates activities not observed by the therapist but reported on by the parent.

F. All functional activities (listed in the vertical column) should be assessed in relation to mobility, self-help, positioning and adaptive equipment.

G. See "Enabling Activities for the OT/PT Functional School Screening" for aid in identifying activities for each category. This list is a guide and not necessarily complete.

H. Any functional activity with a level of D="Dependent" or A-"Assistance" must have an indepth evaluation to document the specific area(s) of dysfunction. Any functional activity with a level of S-"Standby" should have an indepth evaluation if deemed necessary by the evaluating therapist. Any functional activity with a level of I-"Independent" should not receive an indepth evaluation. Any student who is recommended for therapy services (individual or consultation) should have an indepth evaluation in the area of dysfunction.

I. Each category has space for therapists to use for notes.

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II. UTILIZATION:

J. Teacher's long-term goals are an important part of program planning and should be listed in the space provided.
K. The handwritten copy of the "OT/PT Functional School Screening" will serve as a report for the screening and will be stapled behind the typed "Evaluation Summary Report (Face Sheet)" as part of the full evaluation report.

III. DISPOSITION:

A. The contact-therapist gives a copy to the co-therapist immediately after completion.
B. The evaluating therapist turns in the original of the "OT/PT Functional School Screening" to the lead therapist with other completed data which make up the initial evaluation or "ARD Summary Report".
C. The lead therapist will review the "OT/PT Functional School Screening" and upon approval submit it, along with the other data which comprise the full report, to the secretary.
D. The secretary will place the student's HCDE file, including the completed report into the therapist's basket for proofing and signing.
E. The therapist returns the file to the secretary who will distribute:

1. original and 1 copy to the school district.
2. 1 copy to the student's HCDE file.
3. 1 copy to the therapist.
4. 1 copy to the physician (when appropriate).

## ENABLING ACTIVITIES FOR THE OCCUPATIONAL/PHYSICAL THERAPIST

## FUNCTIONAL SCHOOL SCREENING

| ACTIVITIES | MOBILITY | SELF-HELP | POSITIONING | ADAPTIVE MATERIALS AND EQUIPMENT |
|---|---|---|---|---|
| CLASSROOM ACTIVITIES | Reaches to floor; picks up pen from sitting; while standing, picks up book from shelf<br>Accesses educational materials<br>Maneuvers in classroom<br>Writes/erases at blackboard | Opens/closes 3-ring binder<br>Gets tape off dispenser<br>Gets things out of desk<br>Handles stapler<br>Organizes papers/desk<br>Handles chalk<br>Sharpens pencil<br>Attends to task<br>Gets library card out of book<br>Quality of writing<br>Gets articles out of purse<br>Typing-handles paper and manipulates parts of a typewriter<br>Gets articles from back pack of a wheelchair<br>Age appropriate handwriting skills<br>Can copy from the board<br>Can follow directions<br>Keeps objects from falling off desk top | Positioning in chair<br>Stands at blackboard<br>Stands in line<br>Can maintain position at typewriter<br>Can get in/out of desk/chair | Hand splints<br>Wheelchair<br>Foot block<br>Standing table<br>Prone stander<br>Bolster chair<br>Chair insert<br>Braces<br>Crutches<br>Special program utilized example: Frostig<br>Writing aids (pencil grips)<br>Dycem<br>Walker<br>Visual Aids<br>Adaptive table service |

## ENABLING ACTIVITIES FOR THE OCCUPATIONAL/PHYSICAL THERAPIST

## FUNCTIONAL SCHOOL SCREENING

| ACTIVITIES | MOBILITY | SELF-HELP | POSITIONING | ADAPTIVE MATERIALS AND EQUIPMENT |
|---|---|---|---|---|
| BATHROOM ACTIVITIES | Maneuvers into stall<br>Transfers safely<br>Reaches toilet paper<br>Reaches towel dispenser | Washes hands<br>Uses toilet paper<br>Can flush toilet<br>Manages clothes<br>Handles female hygiene<br>Voices discomfort when wet/toilet trained<br>Manages catheter<br>Manages urinal | Maintains position safely<br>Safety for staff when transferring<br>Body mechanics<br>Accessibility to sink/ soap/towels | Rails<br>Bed pan<br>Straps<br>Adaptive faucets<br>Raised seat<br>Potty chair<br>Urinal<br>Drainage appliances |
| CAFETERIA AND/OR SNACK ACTIVITIES | Takes tray through line<br>Carries lunch/food on tray to table<br>Can get lunch pail from closet | Handles money<br>Can remove money from pocket/purse<br>Can use straw/spoon/fork/ knife<br>Can open milk carton<br>Eats finger foods independently<br>Feeds self<br>Drinks from a cup<br>Is able to chew solids<br>Can swallow liquids and solids<br>Can open thermos | Maintain position in line<br>Sit in chair independently | Buddy system<br>Adaptive utensils<br>Adapted cup/plate<br>Adapted feeding device<br>Dycem<br>Chair insert<br>Wheelchair<br>Wheelchair tray |

## ENABLING ACTIVITIES FOR THE OCCUPATIONAL/PHYSICAL THERAPIST

## FUNCTIONAL SCHOOL SCREENING

Page 3

| ACTIVITES | MOBILITY | SELF-HELP | POSITIONING | ADAPTIVE MATERIALS AND EQUIPMENT |
|---|---|---|---|---|
| TRANSPORTATION TO AND FROM SCHOOL | Goes up/down curbs and ramps<br>Maneuvers stairs | Manage safety belt | Maintains safe position in seat | Wheelchair<br>H-harness<br>Travel chair |
| LOCOMOTION | Transfers<br>Goes through doorways<br>Maneuvers around obstacles<br>Uneven surfaces<br>Goes up/down stairs<br>Manages crowded halls<br>Maneuvers playground equipment | Opens locker<br>Manages braces and crutches<br>Manages water fountain<br>Propels wheelchair independently<br>Opens/closes doors<br>Manages light switches<br>Finds own way to/from locations | Can adjust positioning in chair<br>Uses proper gait | Wheelchair<br>Chair with wheels<br>Braces/crutches<br>Rails<br>Cane<br>Ramp |
| DRESSING | Can get jacket, etc. from closet<br>Can reach feet for socks and shoes<br>Can reach top of head for caps<br>Reaches back for zipper | Jacket/pullover-off/on<br>Push down/pulls up pants<br>Shoes/socks off/on<br>Fasteners-buttons, zips, snaps, hooks<br>Braces off/on<br>Ties/unties | Maintains balance in various positions | Corner seat<br>Wheelchair<br>Assistive devices: button, hook, zipper pull<br>Wedge<br>Adaptive clothing<br>Low chair |

## ENABLING ACTIVITIES FOR THE OCCUPATIONAL/PHYSICAL THERAPIST

## FUNCTIONAL SCHOOL SCREENING

Page 4

| ACTIVITIES | MOBILITY | SELF-HELP | POSITIONING | ADAPTIVE MATERIALS AND EQUIPMENT |
|---|---|---|---|---|
| P.E./A.P.E. | Fatigues easily<br>Appropriate development level<br>Maneuverability and able to keep up | Endurance<br>Rhythm<br>Social interaction<br>Success | Safety<br>Able to position for each activity | Adapted scooter boards<br>Mats/wedges<br>Beep balls<br>Wheelchair<br>Prone stander<br>Tilt table |

# PROCEDURES FOR ALL INDEPTH EVALUATIONS

## I. PURPOSE:

Comprehensive assessment to document the student's functional deficits in areas related to suspected disability.

## II. UTILIZATION:

A. Completing Evaluation Protocols:

1. Complete only the student's Name, Date Tested and Date of Birth in the biographical data section.
2. Fill in all evaluation data as completely as possible.
3. Sign and date the protocol upon completion of the evaluation. (Be sure to sign your professional title, i.e., LPT, OTR).

B. Completing the NCR Report Form:

1. Complete only the student's Name, Date Tested and Date of Birth in the biographical data section.
2. Complete the report form as fully as possible up to "Interpretation:"
3. Complete "Interpretation:" only if the data presented requires an explanation.
4. Sign each report form and include your professional title as well as giving the date of completion.

C. Completing the "Clinical Report Form":

1. Complete biographical data as stated above.
2. List and underline the name of the actual test administered (e.g., Range of Motion) and write a brief narrative including specific testing results.
3. If the space provided on the "Clinical Report Form" is not adequate, use the "Continuation Sheet".

D. All Report Forms will be stapled behind the typed "Evaluation Summary Report (Face Sheet)" as part of the full evaluation report.

## III. DISPOSITION:

A. The therapist turns all indepth evaluation protocols and report forms in to the lead therapist along with other initial evaluation data.

B. The lead therapist will review all protocols and report forms and upon approval will submit this data, along with the full report, to the secretary.

C. The secretary will place the student's HCDE file, including the completed report, (with attached forms) into the therapist's basket for proofing and signing.

D. The therapist will return the file to the secretary who will distribute:

1. original and 1 copy to the school district
2. 1 copy to the student's HCDE file
3. 1 copy to the therapist
4. 1 copy to the physician (when appropriate)

E. All protocols are considered raw data and will be maintained in the student's HCDE file only.

## STANDARDIZED TESTS

**DEFINITION** This is a test which has been normed in some specific manner. This means demographic information such as age, sex, race, place, socio-economic occupational and educational data is included. Often several norming groups are defined so that comparisons may be made for a variety of groups. (e.g., blind, deaf, regional area.)

Directions for giving the test are very carefully determined and must be followed exactly to obtain valid results. This includes the setting, (quiet, non-anxious, comfortable, cool, etc.), the verbal and non-verbal instructions, size of the group to be tested and the materials used. In order to ensure validity of results, the tester should have taken the test herself and given the test as many times as it takes to feel comfortable in giving it.

Scoring and interpretation is done in a fixed manner. This means the tester must be familiar with the manual and any data needed to make interpretations. Raw scores may be converted to a variety of standard scores based on the norms available. Scores must be re-checked to ensure accuracy. Interpretation depends upon the reliability and validity of the standardized materials.

A test is devised to meet certain criterion. If the test is not given for those reasons or within those guidelines (i.e., ages), it is not valid.

**PROBLEMS** Often a new tester tends to be too lenient in scoring and interpretation. They are often rushed and have a pre-determined mind set. Tests are subject to:

a) Halo effect = rating an examinee high on one area because he rates high on others.

b) Leniency error - the tendency to rate higher on a positive characteristic and less severely on a negative characteristic than he or she actually should be rated.

c) Central Tendency Error - The tendency to avoid all extreme judgements and rate down the middle on a rating scale.

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| | |
|---|---|
| RELIABILITY | The extent to which a test measures anything consistently.<br>A reliable test is one relatively free from errors of measurement which means results are close in numerical value to true scores.<br>This is the dependability, stability or trustworthiness of the test.<br>Types of Reliability:<br>1) Test/re-test: The same test is given to the same population two times and then the correlation between the scores is computed.<br>2) Parallel Forms (equivalent or alternate forms): Two tests containing the same types of items of equal difficulty are administered to the same population. A correlation is computed to show how close the results are.<br>3) Internal consistency: This is the extent to which the items comprising a test measure the same thing. (e.g., Split-Half: Often the odd items of the test are given to one group and the even items to another and a correlation computed between the two halves. |
| VALIDITY | The extent to which a test measures what it is designed to measure is its validity.<br>Types of Validity:<br>1) Content or Face: How the test looks and whether the items measure what is meant to be measured.<br>2) Criterion: This includes its concurrent and predictive validity or how it measures up to the criterions that are being tested.<br>3) Construct: This is an indepth study of the extent to which the test is a measure of a certain trait as related to a measure of behavior in situations where the trait is thought to be an important variable. |

## DEVELOPMENTAL EVALUATION

NAME: ______________________ DATE: ______________________

BIRTHDATE: ______________________

Data Key: Su = Supine; Pr = Prone; VS = Ventral Suspension

Scoring: + = Passed, 0 = Failed

| | GROSS MOTOR | | FINE MOTOR | |
|---|---|---|---|---|
| 1 MONTH | 1. Su: ATNR predominates | | 1. Hands predominately closed | |
| | 2. VS: head droops | | 2. Hands clench on contact with rattle | |
| | 3. Pull to sit: predominant head lag | | 3. Makes windmill movements with extended arm or arms at head/shoulder region | |
| | 4. Pr: crawling movements | | 4. Momentarily regards objects in line of vision only and as it moves toward midline, will track very briefly. | |
| | 5. Pr: rotates head | | 5. Pauses briefly in activity when bell rung. | |
| | 6. Sit: back evenly rounded -- with movement, lifts head | | | |
| 2 MONTHS | 1. Su: Side position head predominates | | 1. Hands frequently open | |
| | 2. Su: rolls part way to side | | 2. Holds rattle momentarily | |
| | 3. VS: lifts head | | 3. When ring brought up from feet level to above chest level, will turn head and look at ring or hand, moving head slightly. | |
| | 4. Pull to sit: moderate head lag | | 4. Eyes widen, frown or smile when bell rung. | |
| | 5. PR: head in midline, lifts chin off bed 45° | | 5. Vision encompasses 90° | |
| | 6. Sit: less rounding; head bobs | | | |
| 3 MONTHS | 1. Su: head occasionally midline | | 1. Hands loosely open or both hands fisted simultaneously. | |
| | 2. Pr: Props on forearms | | 2. Holds rattle for a minute or more. | |
| | 3. Pr: lifts head 45° - 90° | | 3. Su: regards hands or rattle in hand. Definite visual fixation on object. | |
| | 4. Pr: hips extended, knees flexed | | 4. Vision encompasses 180° | |
| | 5. Sit: head held up, bobs forward | | 5. Beginning to regard object when brought up just past feet level. | |
| | 6. Stand: lifts foot | | | |
| 4 MONTHS | 1. Su: head in midline | | 1. Hands to midline | |
| | 2. Pr: head and chest off bed 90° | | 2. Overshoots when reaching for object. | |
| | 3. Pull to sit: slight head lag | | 3. Holds rattle prolonged and shakes it, but cannot retrieve it if dropped. | |
| | 4. Sit: head held up constantly | | 4. Looks from cube to hand | |
| | 5. Sit: back curved in lumbar region only | | 5. Su: fingers, scratches, clutches | |
| | 6. Sit: head unsteady with sudden sway | | 6. Prefers head at midline | |

| | GROSS MOTOR | | FINE MOTOR | |
|---|---|---|---|---|
| 5 MONTHS | 1. Pr: arms extended<br>2. Pr: weight on hands (elbows not fully extended<br>3. Pr: weight bear on one arm to reach for object<br>4. Pull to sit: no head lag<br>5. Sit: back straight<br>6. Sit: head steady with sudden sway<br>7. Stand: bears most of weight | | 1. Grasps cube on contact and lifts off table top, not just maintain contact.<br>2. Objects to mouth<br>3. Bidextrous approach to grasp<br>4. Holds 1st cube, regards 2nd<br>5. Precarious grasp of cube - Cube held between fingers and heel of palm, usually at ulnar side | |
| 6 MONTHS | 1. Su: rolls to prone<br>2. Su: lifts legs high in extension and plays with feet<br>3. Pr: weight on hands (elbows fully extended) chest, upper abdomen off bed<br>4. Pull to sit: assists with head<br>5. Sit: supported with lateral supports<br>6. Stand: bears almost full weight when held | | 1. Holds bottle with both hands<br>2. Palmar grasp<br>3. Picks up dropped cube<br>4. Reaches and grasps on sight; will go after a cube to get it if it is in sight.<br>5. Drops one cube when given another | |
| 7 MONTHS | 1. Su: feet to mouth<br>2. Su: lifts head<br>3. Pr: one hand support (to reach and grasp<br>4. Sit: leans forward with hands for support<br>5. Bounces in standing | | 1. Feeds self with cookie<br>2. Radial palmar grasp at cube<br>3. Rakes at pellet with whole hand contacts, but cannot grasp<br>4. Unidextrous approach<br>5. Holds one cube, grasps another<br>6. Shakes, bangs rattle, bell<br>7. Transfers cube hand to hand | |
| 8 MONTHS | 1. Pr: pivots on stomach<br>2. Sit: alone one minute<br>3. Sit: leans forward and re-erects<br>4. Stand: supports full weight momentarily | | 1. Pushes one cube against other<br>2. Radial raking of pellet<br>3. Grasps one cube in each hand and retains<br>4. Transfers smoothly-fingers don't get caught with each other during transfer | |
| 9 MONTHS | 1. Sit: alone 10 minutes<br>2. Pr: assumes sit by pushing with hands<br>3. Pr: pushes backwards with arms in attempt to crawl<br>4. Pulls to stand holding on to furniture<br>5. Pr: assumes quadruped, maintains, rocks | | 1. Radial digital grasp of cube<br>2. Scissors grasp of pellet<br>3. Crude release of cube<br>4. Drops one of two cubes to grasp 3rd cube presented<br>5. Holds string with hand and visually regards ring at end of string<br>6. Uses both hands in play | |
| 10 MONTHS | 1. Sit: goes over to prone<br>2. Sit: steady with little risk of overbalancing/lateral balance reactions<br>3. Crawls on abdomen pulling with arms | | 1. Pokes at pellet with index finger<br>2. Grasps bell by handle<br>3. Pellet - grasps promptly using inferior pincer grasp while holding bottle in other hand<br>4. Puts cubes in container without release<br>5. Brings two cubes into close proximity as tho comparing them | |

| | GROSS MOTOR | | FINE MOTOR | |
|---|---|---|---|---|
| 11 MONTHS | 1. Sit: scoots | | 1. Easy release of cube | |
| | 2. Pr: creeps on hands and knees | | 2. Picks up and releases several cubes one by one | |
| | 3. Stands at furniture-lifts foot | | 3. Pincer grasp emerging | |
| | 4. Stand: lowers self with some control | | 4. Grasps end of bell handle with fingers, not hand | |
| | | | 5. Plucks string of ring easily | |
| | | | 6. Will reach for feet or ball image in a mirror | |
| 12 Months - 15 Months | 1. Crawls well | | 1. Holds cup | |
| | 2. Crawls over low barrier | | 2. Turns pages 4-5 at a time | |
| | 3. Cruises along furniture | | 3. Removes 1" peg from pegboard | |
| | 4. Kneels without support | | 4. Puts 1" peg in pegboard | |
| | 5. Walks with hand held | | 5. 2 cube tower | |
| | 6. Stands alone | | 6. Scribbles spontaneously | |
| | 7. Moves from sitting to standing | | 7. Release pellet into bottle with voluntary release | |
| | 8. Seats self in small chair | | 8. Opposition | |
| | 9. Creeps stairs | | 9. 4 rings on peg | |
| | 10. Sit: balance reactions backwards | | 10. Imitates circular motion | |
| | 11. Rolls ball forward in imitation | | 11. Beginning to throw objects | |
| | 12. Standing: throws ball with some cast | | 12. Feeds self with finger or spoon | |
| | | | 13. Inserts round block | |
| 16 Months - 24 Months | 1. Walks into large ball | | 1. Builds 3-4 cube tower | |
| | 2. Beginning to jump | | 2. Releases cube at will | |
| | 3. Climbs into adult chair | | 3. Takes off socks | |
| | 4. Seats self in small chair | | 4. Unzips | |
| | 5. Beginning to run | | 5. Fills cup with cubes | |
| | 6. Stands on one foot with help | | 6. Drops pellet in bottle | |
| | 7. Walks-pulling toy | | 7. Manages spoon | |
| | 8. Walk-sideways, backwards | | 8. Turns pages 2-3 at a time | |
| | 9. Stairs - with one hand held | | 9. Imitates pushing of cube train | |
| | 10. Throws ball-no falling | | 10. Forms - piles blocks when given 3 shapes | |
| | 11. Walks backward in imitation | | 11. On verge of imitating-vertical stroke-may scribble | |
| | 12. Walks downstairs-one hand held | | | |
| | 13. Squats in play | | | |
| 2 Years | 1. Squats to pick up objects without falling | | 1. Turns doorknob | |
| | 2. Bounces small ball | | 2. Turns page one at a time | |
| | 3. Kicks large ball | | 3. Builds 6-7 cube tower | |
| | 4. Jumps forward | | 4. Unscrews lid of jar | |
| | 5. Jumps in place with both feet | | 5. Strings 5 beads in 2 minutes | |
| | 6. Jumps from 12" (1 foot lead) | | 6. Unzips | |
| | 7. Stairs - up and down-non-recipr. | | 7. Imitates '\|' and '___' | |
| | 8. Uses heel-toe gait | | 8. Unwraps small objects | |
| | 9. Rise from supine with mature pattern | | 9. Completes 3 piece formboard | |
| | 10. Turns corner-no pivot turn | | 10. Overgrasps/over releases | |
| | 11. Runs fairly well | | 11. Drops pellet in bottle | |
| | 12. Walks backwards | | 12. Takes off shoes/socks | |
| | | | 13. Imitates train with cubes | |

| | GROSS MOTOR | | FINE MOTOR | |
|---|---|---|---|---|
| 2 Years | 13. Stands on tip-toe | | 14. Circle-imitates strokes | |
| | 14. Forward somersault with aid | | 15. Paper folding-doesn't crease | |
| | 15. Tries to stand on one foot | | 16. Holdspencil in hand instead of fist | |
| | 16. Throws ball 5-7 feet vertically/ horizontally | | | |
| 3 Years | 1. Rides trike | | 1. Builds 3 block tower | |
| | 2. Jumps from bottom step | | 2. Imitates block bridge | |
| | 3. Jumps in place | | 3. Crudely imitates +/0 | |
| | 4. Walks a straight line - 1-3 steps off | | 4. Cuts with scissors 8' line within 1/4" of line | |
| | 5. Walks backwards | | 5. Strings 8 beads in 2 minutes | |
| | 6. Walks sideways | | 6. Close fist and wiggle thumb | |
| | 7. Walks on tip-toes | | 7. Color with crayon, hold in radial fingers | |
| | 8. Marches | | 8. Traces templates | |
| | 9. Runs on toes | | 9. Keyway sticks L/+ model remains | |
| | 10. Reciprocal arm swing | | 10. Folds paper twice | |
| | 11. Stairs-up-alternating feet (alone) | | 11. Solves formboard | |
| | 12. Stairs-down 2 feet/stair (alone) | | 12. Unbuttons | |
| | 13. Throws ball with direction | | 13. Unlaces | |
| | 14. Catches large ball with arm extended | | | |
| | 15. Kicks ball when rolled | | | |
| | 16. Stands on one foot for 3 seconds | | | |
| | 17. Sommersaults forward | | | |
| 4 Years | 1. Mature locomotion with arm swing | | 1. Buttons (large) | |
| | 2. Mature rising | | 2. Imitates cube gate | |
| | 3. Stands on one foot 4-8 seconds | | 3. Imitates keyway stick □ | |
| | 4. Turns corners-starts/stop | | 4. Folds paper 3 times | |
| | 5. Downstairs-one foot per step | | 5. Draws 3 part man | |
| | 6. Runs smoothly at different speeds | | 6. Touch point of nose-eyes closed | |
| | 7. Skips on one foot | | 7. Places 20 coins in box | |
| | 8. Jumps-running or standing | | 8. Traces/copies cross | |
| | 9. Somersaults well | | 9. Adult like pencil grasp | |
| | 10. Running broad jump 23-33" | | 10. Laces shoes | |
| | 11. Standing broad jump 8-10" | | 11. Brushes teeth | |
| | 12. Hops on one foot 4-9 times | | 12. Washes/dries face | |
| | 13. Catches large ball | | 13. Builds 10 block tower | |
| | 14. Walks balance beam-may step off 4 times | | 14. Works simple puzzle | |
| | 15. Throws small ball 9' | | 15. Cuts fairly accurately with scissors | |
| | 16. Throws small ball overhand | | 16. Releases objects with full ext. of fingers | |
| | 17. Bounces and catches a ball cooperatively with another | | 17. Screws together threaded object | |
| | 18. Jumps backwards 6 times | | 18. Puts paper clip on paper | |

|  | GROSS MOTOR |  | FINE MOTOR |  |
|---|---|---|---|---|
| 5 Years | 1. Stands still on toes | ____ | 1. Copies triangle | ____ |
|  | 2. Stands on one foot for 8 seconds | ____ | 2. Cuts on straight line ¼" from edge | ____ |
|  | 3. Alternate feet descending stairs | ____ | 3. Draws 4 part man | ____ |
|  | 4. Hops on one foot 10 times-for 16 feet | ____ | 4. Attempts to stay within line when coloring | ____ |
|  | 5. Skips | ____ | 5. Nests boxes correctly | ____ |
|  | 6. Walking board-may step off 2 times | ____ | 6. Copies square | ____ |
|  | 7. Running broad jump 28"-35" | ____ | 7. Handles medium buttons | ____ |
|  | 8. Catches bounced ball | ____ | 8. Sewing card by turning over | ____ |
|  | 9. Walks on heels | ____ | 9. Uses pencil sharpener with aid | ____ |
|  | 10. Throws small ball 13 feet | ____ | 10. Tears simple shapes from paper | ____ |
|  | 11. Catches small ball from 5' with 2 hands | ____ |  |  |
|  | 12. Standing broad jump 18-24" | ____ |  |  |
|  | 13. Throws ball overhand with direction | ____ |  |  |
|  | 14. Dribbles ball | ____ |  |  |
|  | 15. Picks up object from ground while running | ____ |  |  |
|  | 16. Hangs on bar 10 seconds with arms | ____ |  |  |
| 6 Years | 1. Stands on each foot with eyes closed for 4 seconds | ____ | 1. Copies diamond | ____ |
|  | 2. Skips well | ____ | 2. Spreads with knife | ____ |
|  | 3. Jump from 12" lands on toes | ____ | 3. Copies printing | ____ |
|  | 4. Running broad jump 36-39" | ____ | 4. Ties bow | ____ |
|  | 5. Hurdle jump 12-14" | ____ | 5. Handles small buttons | ____ |
|  | 6. Vertical jump 6-7 inch | ____ | 6. Blows nose | ____ |
|  | 7. Beginning to jump rope | ____ | 7. Uses pencil sharpener independently | ____ |
|  | 8. Balances on one foot-arms folded 10-20 seconds | ____ | 8. Uses eraser | ____ |
|  | 9. Runs in proper fashion | ____ | 9. Draws line with ruler | ____ |
|  | 10. Throws ball at target | ____ | 10. Copies rectangle | ____ |
|  | 11. Catches ball from 5 feet with one hand | ____ |  |  |
|  | 12. Strikes ball thrown from 5 feet | ____ |  |  |
|  | 13. Learning to pitch underhand | ____ |  |  |
|  | 14. Uses hands more than arms in catching ball | ____ |  |  |
|  | 15. Bounces and catches ball independently using both hands | ____ |  |  |
| 7 Years | 1. Good jumping jacks | ____ | 1. Builds 6 block pyramid from memory | ____ |
|  | 2. Heel to toe balance - 5 seconds | ____ | 2. Fair sequential opposition | ____ |
|  | 3. Balance on one foot with arms folded 15-30 seconds | ____ | 3. Can cut meat | ____ |
|  | 4. Balance on one foot with eyes closed - 5 seconds | ____ | 4. Trace through 2 mazes | ____ |
|  | 5. Walks 3" wide beam | ____ | 5. Distributes 36 cards in 4 piles | ____ |
|  | 6. Walks backward heel to toe | ____ | 6. Accurately taps suspended ball | ____ |
|  |  |  | 7. Threads large needle | ____ |
|  |  |  | 8. Copies ◇ ◊ | ____ |

| | GROSS MOTOR | | FINE MOTOR | |
|---|---|---|---|---|
| 7 Years | 7. Jumps over 6" high rope with feet together | | | |
| | 8. Jumps into small squares | | | |
| | 9. Taps floor alternately with feet | | | |
| | 10. Jumps rope clumsily | | | |
| | 11. Catches ball after it's thrown against the wall and bounced once | | | |
| | 12. Front rolls | | | |
| | 13. Throws over hand with direction | | | |
| | 14. Bounces and catches ball with one hand | | | |
| | 15. Learning to bat ball | | | |
| 8 Years | 1. Crouches on tip toes without falling | | 1. Laces 8 beads in 20 seconds | |
| | 2. 2-2; 1-2; 2-1; hop | | 2. Places 10 pairs of matches in box in 16 seconds | |
| | 3. Jumps with feet together height of 12-14" | | 3. Cuts well with scissors | |
| | 4. Jumps over swinging rope 2 times in a row | | 4. Good sequential opposition | |
| | 5. Strikes ball with bat thrown from 5' | | 5. Combs/brushes hair | |
| | 6. Runs and kicks rolled ball | | 6. 15 block tower | |

NAME: ______________________________ DATE TESTED: ______________________________

BIRTHDATE: ______________________________

## DEVELOPMENTAL EVALUATION REPORT

A developmental evaluation in the areas of ____Gross Motor has been given to ______________
____Fine Motor (Name)
on ______________.
(Date)

Based on the available data from the Harris County Developmental Evaluation; gross-motor development appears to be at approximately the ______mo/yr. level. Mastered skills include: ______________________________________________

______________________________________________

Exception: ______________________________________________

Reason for exception: ______________________________________________

______________________________________________.

______________________ also demonstrated skills at the ________ age level. These include:
(Name)

______________________________________________

______________________________________________

Fine motor development appears to be at approximately the ______mo/yr. level. Mastered skills include: ______________________________________________

______________________________________________

Exception: ______________________________________________

Reason for exception: ______________________________________________

______________________________________________.

______________________ also demonstrated skills at the ________ age level. These
(Name)
include: ______________________________________________

______________________________________________.

INTERPRETATION:

______________________________ ______________________________
Signature Date

| | |
|---|---|
| TITLE | Bruininks-Oseretsky - Test of Motor Proficiency |
| ES | 4.5 to 14.5 years |
| PURPOSE | Tests motor proficiency in fine and gross motor areas to enable educators to develop and evaluate motor programs. |
| TESTING TIME | 45-60 minutes for the battery<br>- short form = 15 - 20 minutes |
| LEVELS | Short form = 14 items from the battery of 46 items. |
| SCORES | Standard score - mean of 50, standard deviation of 10<br>Age Equivalents, Percentile Rank and Stanine. |
| RELIABILITY | Criterion Referenced; Test/re-test with 7-12 days<br>Grade 2 - .89<br>Standard Error of Measurement = 4.6<br>Inter-rater - .79 to .97. |
| VALIDITY | Rotated factor loadings<br>Construct Validity - compared with motor development assessed in research studies<br>- comparing normal with handicapped<br>1) general motor development<br>2) upper limb coordination<br>3) balance<br>4) strength<br>5) bilateral coordination |
| CONTENT | There is a pretest to determine arm and leg preference.<br>Items included timed running, strength balance and coordination activities. |
| SUBTESTS | 1) Running speed and agility (1 item)<br>2) Balance (8 items)<br>3) Bilateral Coordination (8 items)<br>4) Strength (4 items)<br>5) Upper Limb Coordination (9 items)<br>6) Response Speed (1 item)<br>7) Visual-Motor Control (8 items)<br>8) Upper Limb Speed and Dexterity (8 items) |
| NORMS | Total of 379 boys and 386 girls ranging in age from 4.6 to 14.5<br>Whites and non-whites in proportion to census; control, suburban and rural.<br>50% North Central, Northeast, South, and West |
| COMMENTS | Takes practice to administer; need a room, need time to set up; student needs tennis shoes; easy to score.<br>Useful to update after Ayres Battery has been administered for relatively high functioning handicapped students.<br>Good for L.D.<br>Needs practice to administer.<br>Heavy but comprehensive kit.<br>Manual is well organized, easy to use and the pictures on test administration are very helpful. |

| | |
|---|---|
| PUBLISHER | American Guidance Service |
| [illegible]THOR | Robert H. Bruininks |
| DATE | 1978 |
| REVIEWS | Doll, E.A., Ed., The Oseretsky Tests of Motor Proficiency. Circle Pines, Minnesota American Guidance Service, 1944 |

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| | |
|---|---|
| TITLE | Test of Motor Impairment |
| AGE | 5-13 |
| PURPOSE | To detect motor impairment where behavior disorders and learning disabilities are the primary symptoms.<br>To measure subtle neurological impairment. |
| TIME | 20 minutes to test and 2 minutes to score |
| LEVELS | There is a level for each age. |
| SCORES | Each item is scored 0 = pass, 1 = pass on 1 side, 2 = fail<br>Testing continues upwards or downwards from age level until all 5 items at a level are passed.<br>Raw scores are totalled to give the general impairment score. |
| VALIDITY | Teachers were asked to pick out 60 students aged 6-8 who they thought showed motor impairment. 60 controls were also chosen. The teachers rated all 120 students as:<br>1) Good<br>2) Average<br>3) Poor<br>They also rated them on a scale broken into 5 motor areas.<br>All students were given the test and the tetrachoric correlation - .85 between the 5 test breakdown and the Stott, Moyes, Henderson. Test/re-test on 24 children with 2-4 week delay between tests = .93. A study was done to show that there is an increase in maladaption with an increase in motor impairment. |
| CONTENT | There are 5 items for each of the following age levels:<br>sub 5, 5, 6, 7, 8, 9, 10, 11-12, 13 +.<br>Each level includes a balance activity, eye-hand activities, co-ordination activity and fine motor activity. |
| NORMS | 854 children aged 6-15 attending schools in an industrial city in Ontario born the 15th or 16th of any month. The 31 schools were divided into 4 socio-economic groups and subjects were drawn proportionally.<br>Students were tested at their age level plus those above and below. Average fail rates were 15.49% for boys; 12.88% for girls. |
| COMMENTS | Score sheet is easy to follow and score.<br>Manual is not as well organized as some.<br>The description and picture of each item is very helpful.<br>Kit is heavy. |
| PUBLISHER | Brook Educational Publishing Ltd. |
| AUTHOR | D. H. Stott, F. A. Moyes, S.E. Henderson |

**TLE** Denver Developmental Screening Test (DDST)

**AGE** 2 weeks up to 6 weeks

**PURPOSE** To determine developmental delays early on.

**TIME** 1/4 hour to 1 hour depending on the level of the child. This includes testing and scoring.

**SCORES** The child is tested upwards until he fails at 3 activities in a row in each sector. Three trials are given.

Scoring is by P = pass; F = fail; R = refusal; N.O. = no opportunities. Delays are those where 90% of the children tested at that age would pass and that part of the bar is shaded to distinguish it.

The score is:

| | |
|---|---|
| Normal | |
| Questionable | - 1 sector with 2 or more delays<br>- 1 sector with 1 delay and no passes at age |
| Abnormal | - 1 sector with 2 or more delays |
| Untestable | - several refusals |

**RELIABILITY** Test/re-test - 20 children 2 months to 5-1/2 years tested one week apart
- agreement was 95.8%

Intertester reliability - between 4 examiners on 12 children
= 90%

**VALIDITY** 236 children were administered Stanford-Binet or Bayley Scale. There was a high correlation in intertesting results.

**CONTENT/ SUBTESTS** There are 105 test items appropriate by age in 4 categories from 12 existing developmental and pre-school tests.

1) Gross Motor
2) Language
3) Fine Motor-Adaptive
4) Personal Social

Each item is placed on a bar graph with percentage marks.

**NORMS** 1036 Denver children (543 male, 493 female) aged 2 weeks to 6.4 years were utilized. The choice of subjects was in accordance to 1960 census data (i.e., white 82%, Spanish 11%, Black 7%, occupation of father).

**COMMENTS**
Inexpensive
Easy to learn and administer
Graphic results
Should be used only as a screener
Manual is well designed. A self instructional packet
Kit is easy to carry
Norm group needs to be enlarged geographically

**BLISHER** University of Colorado Medical Center

**AUTHOR** W. K. Frankenburg, M.D., J. B. Dodds, Ph.D., Alma W. Fandal

**DATE** 1973

NAME: ______________________ DATE: ______________________

BIRTHDATE: ______________________

## SELF HELP SKILLS SCREENING

KEY: + = can do or is present; 0 = needs assistance or is absent; ✓ = further evaluation indicated

| ✓ | 0/+ | UNDRESSING SKILLS | ✓ | 0/+ | DRESSING SKILLS |
|---|---|---|---|---|---|
| | | Removes coat/jacket | | | Puts on coat/jacket |
| | | Removes shoes | | | Puts on shoes |
| | | Removes socks | | | Puts on socks |
| | | Removes pullover garment | | | Puts on pullover garment |
| | | Unbuttons | | | Buttons |
| | | Unzips | | | Zips |
| | | Unties | | | Ties shoes |
| | | Removes splints/braces | | | Puts on splints, braces |

COMMENTS:

| ✓ | 0/+ | TOILETING SKILLS | ✓ | 0/+ | GROOMING SKILLS |
|---|---|---|---|---|---|
| | | Voices discomfort when wet | | | Washes/dries hands |
| | | Indicates need for toilet use | | | Washes/dries face |
| | | Uses urinal (if applicable) | | | Combs/brushes hair |
| | | Pulls pants down | | | Brushes teeth |
| | | Uses toilet paper | | | Uses tissue to wipe nose |
| | | Pulls pants up | | | Shaves |
| | | Closes pants/belt | | | Bathes/showers |
| | | Flushes toilet | | | |
| | | Washes hands after use | | | |

COMMENTS:

| ✓ | 0/+ | FEEDING SKILLS | ✓ | 0/+ | FEEDING PROBLEMS: |
|---|---|---|---|---|---|
| | | Must be fed | | | Excessive drooling |
| | | Opens mouth for food | | | Breathes through mouth only |
| | | Feeds self cookie | | | Strong tongue thrust reflex |
| | | Drinks from cup | | | Poor jaw stability |
| | | Eats with spoon | | | Difficulty swallowing |
| | | Drinks through straw | | | Difficulty chewing |
| | | Eats with fork | | | |
| | | Cuts with knife | | | |
| | | Chews with mouth closed | | | |

ASSISTIVE DEVICES:

| ✓ | 0/+ | FUNCTIONAL MOBILITY | ✓ | 0/+ | USE OF WHEELCHAIR |
|---|---|---|---|---|---|
| | | Rolls | | | Propels forward |
| | | Crawls in prone | | | Propels backward |
| | | Scoots (position: ) | | | Negotiates on carpeting |
| | | Bunnyhops-all fours | | | Adjusts sitting posture in wheelchair (chair) |
| | | Creeps on all fours | | | Transfers out of wheelchair (chair) |
| | | Knee walks | | | Transfers into wheelchair (chair) |
| | | Cruises | | | Wheelchair to floor |
| | | Ambulates without assistive devices | | | Floor to wheelchair |
| | | Ambulates with assistive devices | | | Must be placed in wheelchair |
| | | Uses wheelchair | | | Must be transported in wheelchair |

Interpretation of Screening:

Recommendations:

Signature

Date

NAME: ______________________________ DATE: ______________________________

BIRTHDATE: ______________________________

SELF HELP SKILLS

DRESSING EVALUATION:

| SKILLS: | Independent-will perform without verbal cues | Supervision for safety only | Supervision for verbal cues | Minimal assistance-can do most of activity | Moderate assistance-can do part of activity | Maximum assistance-can help or indicate need for help | Totally dependent in activity | T-Actually tested R-Reported by Teacher/ Parent | |
|---|---|---|---|---|---|---|---|---|---|
| UNDRESSING | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
| Removes coat/jacket | | | | | | | | | |
| Removes pullover garment | | | | | | | | | |
| Removes shirt/blouse | | | | | | | | | |
| Removes undershirt/bra | | | | | | | | | |
| Removes slacks/dress | | | | | | | | | |
| Removes shoes | | | | | | | | | |
| Removes stocking/socks | | | | | | | | | |
| Unbuttons | | | | | | | | | |
| Unzips | | | | | | | | | |
| Unsnaps | | | | | | | | | |
| Unties | | | | | | | | | |
| Unlaces | | | | | | | | | |
| Unbuckles | | | | | | | | | |
| Unhooks (nooks and eyes) | | | | | | | | | |
| Removes braces/spints | | | | | | | | | |

| DRESSING | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| Puts on undershirt/bra | | | | | | | | | |
| Puts on shirt/blouse | | | | | | | | | |
| Puts on dress/slacks | | | | | | | | | |
| Puts on pullover garment | | | | | | | | | |
| Puts on stockings/socks | | | | | | | | | |
| Puts on shoes | | | | | | | | | |
| Puts on coat/jacket | | | | | | | | | |
| Buttons | | | | | | | | | |
| Zips | | | | | | | | | |
| Snaps | | | | | | | | | |
| Ties | | | | | | | | | |
| Laces | | | | | | | | | |
| Buckles | | | | | | | | | |
| Hooks (hooks and eyes) | | | | | | | | | |
| Inserts safety pin, closes | | | | | | | | | |
| Puts on braces/spints, etc. | | | | | | | | | |

Adaptive Equipment:

Interpretation of data: (e.g., adaptive behavior, postural observations, perseveration, etc.)

Signature

Date

NAME: ______________________________ DATE: ______________________________

BIRTHDATE: ______________________________

## SELF HELP SKILLS

**GROOMING AND TOILETING EVALUATION**

| SKILLS: | Independent-will perform without verbal cues | Supervision for safety only | Supervision for verbal cues | Minimal assistance-can do most of activity | Moderate assistance-can do part of activity | Maximum assistance-can help or indicate need for help | Totally dependent in activity | T-Actually tested R-Reported by Teacher/Parent | |
|---|---|---|---|---|---|---|---|---|---|
| TOILETING SKILLS | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
| Indicates need for toilet use | | | | | | | | | |
| Goes to bathroom when needed | | | | | | | | | |
| Voices discomfort when wet | | | | | | | | | |
| Pulls pants down | | | | | | | | | |
| Sits on toilet | | | | | | | | | |
| Uses urinal (if applicable) | | | | | | | | | |
| Uses toilet paper | | | | | | | | | |
| Changes sanitary pad(if appl.) | | | | | | | | | |
| Flushes toilet | | | | | | | | | |
| Pulls pants up | | | | | | | | | |
| Closes pants/belt | | | | | | | | | |
| Washes hands after toileting | | | | | | | | | |
| Dries hands | | | | | | | | | |

| GROOMING/HYGIENE SKILLS: | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| Turns on faucet | | | | | | | | | |
| Replaces soap | | | | | | | | | |
| Rinses hands | | | | | | | | | |
| Rinses soap from face | | | | | | | | | |
| Turns off faucet | | | | | | | | | |
| Dries hands | | | | | | | | | |
| Applies toothpaste to brush | | | | | | | | | |
| Brushes teeth | | | | | | | | | |
| Rinses toothpaste/mouthwash from mouth | | | | | | | | | |
| Combs/brushes hair | | | | | | | | | |
| Keeps nose clean/uses tissues | | | | | | | | | |
| Shaves (indicate razor or electric) | | | | | | | | | |
| Showers | | | | | | | | | |
| Bathes | | | | | | | | | |
| Chooses proper toilet articles | | | | | | | | | |
| Replaces articles when finished | | | | | | | | | |
| Leaves area clean, dry following use | | | | | | | | | |

Adaptive Equipment:

Interpretation of data: (e.g., social appropriateness of toileting/grooming behaviors, judgement and caution shown in use of bathroom and toilet articles, etc.)

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Signature

Date

NAME: ______________________ DATE: ______________________

BIRTHDATE: ______________________

## SELF HELP SKILLS

### FEEDING EVALUATION

KEY: + = if present; 0 = not present; Circle if abnormal and comment

| +/0 | Problems areas: | Comments |
|---|---|---|
| | Breathes only through mouth | |
| | Difficulty in swallowing | |
| | Tongue thrust reflex | |
| | Hyper-retracted tongue | |
| | Rooting reflex | |
| | Sucking reflex | |
| | Hyperactive bite reflex | |
| | Hyperactive gag reflex | |
| | Poor jaw stability | |
| | Hypotonic oral musculature | |
| | Excessive saliva | |
| | Refuses certain foods | |
| | Other (please specify) | |

Pertinent medical comments: (e.g., gastrostomy tube, aspiration, allergies to foods, etc.)

|  | Independent-will perform without verbal cues | Supervision for safety only | Supervision for verbal cues | Minimal assistance-can do most of activity | Moderate assistance-can do part of activity | Maximum assistance-can help or indicate need for help | Totally dependent on activity | T-Actually tested R-Reported by Teacher/ Parent |  |
|---|---|---|---|---|---|---|---|---|---|
| FEEDING SKILLS | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
| 1) Opens mouth for food |  |  |  |  |  |  |  |  |  |
| 2) Holds bottle when feeding |  |  |  |  |  |  |  |  |  |
| 3) Eats with fingers |  |  |  |  |  |  |  |  |  |
| 4) Drinks from cup |  |  |  |  |  |  |  |  |  |
| 5) Drinks from glass |  |  |  |  |  |  |  |  |  |
| Eats with spoon |  |  |  |  |  |  |  |  |  |
| 7) Drinks through straw |  |  |  |  |  |  |  |  |  |
| 8) Pours liquid |  |  |  |  |  |  |  |  |  |
| 9) Eats with fork |  |  |  |  |  |  |  |  |  |
| 10) Spreads with knife |  |  |  |  |  |  |  |  |  |
| 11) Cuts with knife |  |  |  |  |  |  |  |  |  |
| 12) Chews with mouth closed |  |  |  |  |  |  |  |  |  |
| 13) Uses napkin |  |  |  |  |  |  |  |  |  |
| 14) Maintains suitable posture |  |  |  |  |  |  |  |  |  |
| 15) Spills minimally |  |  |  |  |  |  |  |  |  |
| 16) Chooses appropriate finger food |  |  |  |  |  |  |  |  |  |
| Chooses appropriate utensil |  |  |  |  |  |  |  |  |  |

A[illegible]tive Equipment:

Interpretation of data: (e.g., social appropriateness of feeding behaviors, table manners, etc.)

Signature

Date

NAME: ______________________ DATE: ______________________

BIRTHDATE: ______________________

## SELF HELP SKILLS

## FUNCTIONAL MOBILITY ASSESSMENT

| SKILLS: | Assistive devices comment | Independent-will perform without verbal cues | Supervision for safety only | Supervision for verbal cues | Minimal assistance-can do most of activity | Moderate assistance-can do part of activity | Maximum assistance-can help or indicate need for help | Totally dependent in activity | T-Actually tested R-Reported by Teacher/ Parent | |
|---|---|---|---|---|---|---|---|---|---|---|
| I. APEDAL | ADC | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
| 1) Pivots in prone | | | | | | | | | | |
| 2[illegible]olls to specific point | | | | | | | | | | |
| 3) Crawls or body pulls with arms | | | | | | | | | | |
| 4) Scoots in supine, pushing with legs | | | | | | | | | | |
| 5) Pivots in sitting | | | | | | | | | | |
| 6) Scoots in sitting forward | | | | | | | | | | |
| 7) Scoots in sitting backwards | | | | | | | | | | |
| II. QUADRUPEDAL | | | | | | | | | | |
| 1) Pivots on all fours | | | | | | | | | | |
| 2) Bunny hops | | | | | | | | | | |
| 3) Creeps ipsilaterally | | | | | | | | | | |
| 4) Creeps contralaterally | | | | | | | | | | |
| 5) Plantigrade walking (hands and feet) | | | | | | | | | | |
| 6[illegible]limbs on hands and knees | | | | | | | | | | |

| III. BIPEDAL | ADC | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|---|
| 1) Pivots in kneeling | | | | | | | | | | |
| 2) knee walks forward | | | | | | | | | | |
| 3) Knee walks backward | | | | | | | | | | |
| 4) Assumes half-kneeling | | | | | | | | | | |
| 5) Rises to standing | | | | | | | | | | |
| 6) Stands | | | | | | | | | | |
| 7) Pivots in standing | | | | | | | | | | |
| 8) Cruises | | | | | | | | | | |
| IV. AMBULATION (test with minimal assistive devices | | | | | | | | | | |
| 1) Forward | | | | | | | | | | |
| 2) To right | | | | | | | | | | |
| 3) To left | | | | | | | | | | |
| 4) Backwards | | | | | | | | | | |
| 5) Walks on carpeting | | | | | | | | | | |
| 6) Negotiates small change in surface level | | | | | | | | | | |
| 7) Descends ramp | | | | | | | | | | |
| 8) Ascends ramp | | | | | | | | | | |
| 9) Ascends stairs | | | | | | | | | | |
| 10) Descends stairs | | | | | | | | | | |
| 11) Descends 4" curb | | | | | | | | | | |
| 12) Ascends 4" curb | | | | | | | | | | |
| 13) Goes through door opening away | | | | | | | | | | |
| 14) Goes through door opening toward | | | | | | | | | | |
| 15) Walks on uneven surface | | | | | | | | | | |

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Assistive devices for ambulation:

Observations: (e.g., approximate distance able to travel, functional aspects regarding ability to carry with one or both hands, picking up objects from floor, getting up from floor, need for assistive devices in bathroom, opening doors with knobs and negotiating push-open doors, etc.)

Signature

Date

NAME: ______________________ DATE: ______________________

BIRTHDATE: ______________________

SELF HELP SKILLS

WHEELCHAIR FUNCTIONAL ASSESSMENT

| | Independent-will perform without verbal cues | Supervision for safety only | Supervision for verbal cues | Minimal assistance-can do most of activity | Moderate assistance-can do part of activity | Maximum assistance-can help or indicate need for help | Totally dependent in activity | T-Actually tested R-Reported by Teacher/ Parent | |
|---|---|---|---|---|---|---|---|---|---|
| I. WHEELCHAIR MOBILITY | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
| 1) Propels forward | | | | | | | | | |
| 2) Turns to right | | | | | | | | | |
| 3) Turns to left | | | | | | | | | |
| 4) Backs up | | | | | | | | | |
| 5) Stops motion of chair | | | | | | | | | |
| 6) Negotiates on carpeting | | | | | | | | | |
| 7) Negotiates small change in surface level | | | | | | | | | |
| 3) Descends ramp | | | | | | | | | |
| 9) Ascends ramp | | | | | | | | | |
| 10) Descends 4" curb | | | | | | | | | |
| 11) Ascends 4" curb | | | | | | | | | |
| 12) Negotiates on uneven surface | | | | | | | | | |
| 13) Goes through door opening away | | | | | | | | | |
| 14) Goes through door opening in | | | | | | | | | |

| II WHEELCHAIR MANAGEMENT | I | SS | Sup | Min | Mod | Max | D | T/R | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| 1) Unlocks brakes | | | | | | | | | |
| 2) Locks brakes | | | | | | | | | |
| 3) Removes arm rests | | | | | | | | | |
| 4) Replaces arm rests | | | | | | | | | |
| 5) Removes foot rests | | | | | | | | | |
| 6) Replaces foot rests | | | | | | | | | |
| 7) Unfolds wheelchair preparing for transfer | | | | | | | | | |
| 8) Folds wheelchair following transfer | | | | | | | | | |
| 9) Removes wheelchair from car | | | | | | | | | |
| 10) Places wheelchair in car | | | | | | | | | |
| 11) Seeks repairs for wheelchair when necessary | | | | | | | | | |
| III TRANSFERS | | | | | | | | | Note use of sliding board, grab bars |
| 1) Pushes up in wheelchair | | | | | | | | | |
| 2) Adjusts sitting position in wheelchair | | | | | | | | | |
| 3) Bed to wheelchair | | | | | | | | | |
| 4) Wheelchair to bed | | | | | | | | | |
| 5) Chair to wheelchair | | | | | | | | | |
| 6) Wheelchair to chair | | | | | | | | | |
| 7) Standing to wheelchair | | | | | | | | | |
| 8) Wheelchair to standing | | | | | | | | | |
| 9) Wheelchair to toilet | | | | | | | | | |
| 10) Toilet to wheelchair | | | | | | | | | |
| 11) Wheelchair to bathtub | | | | | | | | | |
| 12) Bathtub to wheelchair | | | | | | | | | |
| 13) Wheelchair to floor | | | | | | | | | |
| 14) Floor to wheelchair | | | | | | | | | |
| 15) Car to wheelchair | | | | | | | | | |
| 16) Wheelchair to car | | | | | | | | | |

Description of wheelchair: (e.g. special adaptions, etc.)

Interpretation of data: (e.g., opening doors, use of public restrooms, use of pay telephone, etc.)

Signature

Date

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## OCCUPATIONAL AND PHYSICAL THERAPY

## REFLEX EVALUATION

NAME: ______________________________ DATE TESTED: ______________________________

BIRTHDATE: ______________________________

GRADING KEY: P = Present Ⓐ = Abnormally Absent
A = Absent E = Emerging Response
Ⓞ = Obligatory Ⓡ = Residual Reflex (may be tonal change only)

| | | | DATES | | | | Months |
|---|---|---|---|---|---|---|---|
| 1. | UPR | Placing Reaction | | | | | 0-1 |
| 2. | UPR | Primitive Stepping | | | | | 0-1 |
| 3. | SUP | Flexor Withdrawal | | | | | 0-3 |
| 4. | SUP | Extensor Thrust | | | | | 0-4 |
| 5. | SUP | Crossed Extension | | | | | 0-4 |
| 6. | SUP | Palmar Grasp | | | | | 0-4 |
| 7. | SUP | Asymmetrical Tonic Neck Reflex | | | | | 0-5 |
| 8. | PR | Symmetrical Tonic Neck Reflex | | | | | 4-6 |
| 9. | 4-Point Kneeling | Symmetrical Tonic Neck Reflex | | | | | 0-5 |
| 10. | SUP | Tonic Labyrinthine | | | | | 0-5 |
| 11. | PR | Tonic Labyrinthine | | | | | 0-5 |
| 12. | SUP | Moro | | | | | 0-7 |
| 13. | UPR | Positive Supporting | | | | | 0-7 |
| 14. | SUP | Neck Righting | | | | | 0-6 |
| 15. | SUP | Plantar Grasp | | | | | 0-13 |
| 16. | SUP | Head Righting (Optical) | | | | | 2→ |
| 17. | PR | Head Righting (Optical) | | | | | 2→ |
| 18. | UPR | Head Righting | | | | | 2→ |
| 19. | SUP | Body Righting on Body | | | | | 7→ |
| 20. | PR | Amphibian Reaction | | | | | 6→ |

|  |  |  | DATES |  |  |  |  |
|---|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  | Months |
| 21. | V.SUSP | Landau |  |  |  |  | 7-48 |
| 22. | 4-Point Kneeling | Protective Extension (forward) |  |  |  |  | 6-7 → |
| 23. | SIT | Protective Extension (sideways) |  |  |  |  | 8-10 → |
| 24. | SIT | Protective Extension (backward) |  |  |  |  | 12-15 → |
| 25. | PR | Equilibrium |  |  |  |  | 7 → |
| 26. | SUP | Equilibrium |  |  |  |  | 8 → |
| 27. | QUAD | Equilibrium |  |  |  |  | 8 → |
| 28. | SIT | Equilibrium |  |  |  |  | 12 → |
| 29. | KN | Equilibrium |  |  |  |  | 15 → |
| 30. | UPR | Hopping (forward) |  |  |  |  | 15-18 → |
| 31. | UPR | Hopping (sideways) |  |  |  |  | 15-18 → |
| 32. | UPR | Hopping (backwards) |  |  |  |  | 15-18 → |
| 33. | UPR | Dorsiflexion (left) |  |  |  |  | 15-18 → |
| 34. | UPR | Dorsiflexion (right) |  |  |  |  | 15-18 → |
| 35. | UPR | See-Saw |  |  |  |  | 15 → |
| 36 | UPR | Simian |  |  |  |  | 18 → |
| 37. |  | Associated Reactions |  |  |  |  |  |

Signature ______________________ Date ______________________

Comments:

Adapted from:
Fiorentino
Millani-Comparetti

## REFLEX EVALUATION DIRECTIONS

| REFLEX | POSITION FOR TESTING | THERAPIST'S ACTIONS | STUDENTS EXPECTED RESPONSE |
|---|---|---|---|
| 1. Placing Reactions | upright, suspended | allow dorsum of foot to brush table | foot is lifted and placed on table top |
| 2. Primitive Stepping | upright, suspended | allow some weight bearing on soles of feet | elicits a step forward of one foot, followed by the other foot |
| 3. Flexor Withdrawal | supine | quick tactile stimulus to the plantar surface | elicits abrupt, uncontrolled flexion of the lower limb |
| 4. Extensor Thrust | supine, one leg flexed and other extended | light pressure to the ball of the flexed foot | total, uncontrolled extension of the flexed leg |
| 5. Crossed Extension | supine, leg flexed and one leg extended | passively flex the extended leg | opposite leg extends with adduction, internal rotation of the hip |
| 6. Palmar Grasp | supine | therapist's finger is placed from the ulnar to radial side of the hand | with stimulation, the child automatically grasps |
| 7. Asymmetrical Tonic Neck Reflex | supine | actively or passively turn head approximately $90^0$ to one side | extension of limbs on nos side, flexion of limbs on skull side<br>- note tonal change |
| 8. Symmetrical Tonic Neck Reflex | over lap or bolster | flexion of head (chin to chest)<br>extension of head | upper extremities flex an lower extremities exten<br>upper extremities extend lower extremities flex |
| 9. Symmetrical Tonic Neck Reflex | four-point kneeling | have the student flex head at shoulder height<br>therapist may passively move the head | tonal change |
| 10. Tonic Labyrinthine | prone | | this position elicits lim flexion or predominantl flexor tone |

| REFLEX | POSITION FOR TESTING | THERAPIST'S ACTIONS | STUDENTS EXPECTED RESPONSE |
|---|---|---|---|
| 11. Tonic Labrynthine | supine, suspended | | this position elicits limb extension or predominantly extensor tone |
| 12. Moro Reflex | supine | drop head backwards from semi-sitting position | sudden extension and abduction of upper extremities with opening of the hands followed by flexion to the midline |
| 13. Positive Supporting Reaction | upright, suspended | bounce him on his feet - test hip abduction, knee flexion and dorsi flexion of ankle before testing positive supporting | elicits extension of both lower limb with plantar flexion of the feet |
| 14. Neck Righting | supine | passively turn head & hold | thorax should follow or reflex is not present |
| 15. Plantar Grasp | supine | pressure on sole of foot at base of toes | flexion of the toes |
| 16. Optical Righting on Head | supine, suspended | head is slightly lowered | head should raise to a vertical position with trunk extension |
| 17. Head Righting | sitting, suspended held by pelvis | tilt to one side | head rights itself to normal |
| 18. Body Righting on Body | supine | passively rotate at shoulder or hip | normal if segmental rotation of shoulders, trunk, pelvis follows |
| 19. Amphibian Reach | prone, head in midline, arms extended over head, legs extended | therapist lifts one side of pelvis | positive reaction is automatic flexion of arm, hip, and knee on same side |
| 20. Landau | prone, suspended by chest | actively or passively dorsi flex head<br>ventro flexion of head | trunk and lower extremity extension<br>flexion of spine and lower extremities |

| REFLEX | POSITION FOR TESTING | THERAPIST'S ACTIONS | STUDENTS EXPECTED RESPONSE |
|---|---|---|---|
| 21. Protective Extension (a)Forward | four point kneeling | abruptly push student forward at hips | forward extension of arms and abduction with abduction and extension of fingers |
| (b)Sideways | sitting | abruptly push student to the side at shoulder level | elicits abduction and extension of arm on raised side with protective extension |
| (c)Backwards | sitting | abruptly push backwards at shoulder level | elicits backward extension of arms |
| 22. Equilibrium | a) prone on board or mat | tilt sideways | head and trunk turn to raised side with abduction and extension of extremities on raised side, protective extension of extremities on lowered side |
| | b) supine on board or mat | tilt sideways | head and trunk turning to raised side with abduction and extension of extremities on raised side, protective extension of extremities on lowered side |
| | c) quadruped on floor | tilt to one side | |
| | d) sitting on floor | tilt the knees from side to side | righting of head and trunk, abduction-extension of arm and leg on raised side and protective extension on other side |
| | e) kneeling | pull or tilt to one side | |
| 23. Hopping a) sideways | standing, hold student by upper arms | move to left or right | elicits righting of head and thorax, hopping to maintain equilibrium |

| REFLEX | POSITION FOR TESTING | THERAPIST'S ACTIONS | STUDENTS EXPECTED RESPONSE |
|---|---|---|---|
| b) forward | standing, hold student by upper arms | move student forward (from behind) | elicits righting of head and thorax, hopping to maintain equilibrium |
| c) backward | standing, hold student by upper arms | move student backward (from infront) | elicits righting of head and thorax, hopping to maintain equilibrium |
| 24. Dorisflexion | standing, hold upper axillae | tilt backwards | righting of head and thorax and dorsiflexion and forward arm movements |
| 25. See Saw | standing, hold hand and foot of same side with hip and knee flexed | pull arm gently forward and slightly to lateral side | extends flexed knee and maintains equilibrium |
| 26. Simian | squat-sitting | tilt to one side | righting of head and thorax, abduction extension of arm and leg on raised side and protective on the lowered side |
| 27. Associated Reactions | | student squeezes object student runs | look for exaggerated movement patterns in other than the tested body part |

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NAME: ______________________________ DATE: ______________________________

BIRTHDATE: __________________________

## REFLEX EVALUATION REPORT

The normal baby at birth has a fully intact nervous system which will continue to develop until he has acquired the skills necessary for his functioning in adult life.

The newborn is a reflexive being and his movements are totally dominated by his primary reflexes. A reflex is defined as an involuntary response to a specific stimulus such as withdrawing a finger from a hot stove.

Normally as the baby develops, his brain matures and modifies these reflexes allowing for the emergence of higher level responses like equilibrium and balance. Persistence of the normal primary reflexes beyond expected age levels may interfere with his growth and development.

A standard reflex evaluation, based on Fiorentino and Miliani-Comparetti, was administered to

______________________ on ______________________.
(Name) (Date)

______________________ demonstrates:
(Name)

_____1. adequately integrated primary reflexes.
_____2. adequately integrated balance reactions.
_____3. adequately integrated equilibrium reactions.

______________________ has persistence of the following primary reflexes: ______________
(Name)

______________________________________________________________________

______________________________________________________________________.

_____inadequate balance reactions.
_____inadequate equilibrium reactions.

These reflexes are interfering with his development of complex skills

_____but do not dominate his motoric patterns.
_____and are dominating his motoric patterns.

INTERPRETATION:

______________________________ ______________________________
Signature Date

NAME: ______________________________ DATE: ______________________________

BIRTHDATE: ______________________________

## CLINICAL EVALUATION

### Muscle Tone

| | Upper Extremities | Trunk | Lower Extremities |
|---|---|---|---|
| 1. Basic tone (at rest) | | | |
| Tremor | | | |
| Fluctuating | | | |
| Hypertonic (Ext., Flexor, Combined) | | | |
| Hypotonic (Extensor, Flexor, Combined) | | | |

2. Tone with head movements (Note area of tonal change and whether Flexor or Extensor)

| | Increased | Decreased | No Change |
|---|---|---|---|
| Head to right | | | |
| Head to left | | | |
| Head flexed | | | |
| Head extended | | | |

3. Tone with effort (Note associated reactions and correlation with reflex testing in regards to upper extremity, trunk and lower extremity.)

Non ambulant (reaching, rolling)

Ambulant (with aids, walking, running)

### Range of Motion

State areas of tightness and give goniometrical measurements - Note any contractures.

| AREA | RANGE IN DEGREES |
|---|---|
| | |
| | |
| | |
| | |
| | |

## [illegible]tor Patterns

Check for asymmetrical postures, resistance to passive movement, movements, righting reflexes, coordination, functional abilities, transfer of weight, and transitional movements.

1. Supine

2. Prone

3. Sitting (Tailor and Sidesitting)

4. All fours

5. Upright kneeling

6. Half kneeling

7. Standing

## Leg Length Discrepancy

Actual - measure from anterior superior iliac spine to medial malleolus
Apparent - measure from belly button to medial malleolus

_____ Left Apparent Measurement

_____ Right Measurement

_____ Left Actual Measurement

_____ Right Measurement

## Limb Girth

State limb; location on limb (give inches to local landmark), side and measurement

## Muscle Strength

List areas of weakness (Fair and Below) and grade

Sensation

List areas of decreased sensation

Posture

List postural deviations

Gait

List problem areas as evidenced by analysis

Comments

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# RANGE OF MOTION

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ____________________

|  | LEFT |  |  |  | RIGHT |  |
|---|---|---|---|---|---|---|
|  |  |  | DATE |  |  |  |
|  |  |  | EXAMINER'S INITIALS |  |  |  |
|  |  |  | MOTION |  |  |  |
|  |  |  | NECK<br>FLEXION 0-35°, 0" |  |  |  |
|  |  |  | EXTENSION 35-0°, 10" |  |  |  |
|  |  |  | LAT. FLEXION 0-45°, 5" |  |  |  |
|  |  |  | ROTATION 0-30°, 5" |  |  |  |
|  |  |  | TRUNK<br>FLEXION |  |  |  |
|  |  |  | EXTENSION |  |  |  |
|  |  |  | LATERAL FLEXION |  |  |  |
|  |  |  | ROTATION |  |  |  |
|  |  |  | HIP<br>FLEXION 0-125° |  |  |  |
|  |  |  | EXTENSION 125-0° |  |  |  |
|  |  |  | HYPEREXT. 0-15° |  |  |  |
|  |  |  | ABDUCTION 0-45° |  |  |  |
|  |  |  | ADDUCTION 0-45° |  |  |  |
|  |  |  | INT. ROTATION 0-45° |  |  |  |
|  |  |  | EXT. ROTATION 0-45° |  |  |  |
|  |  |  | STRAIGHT LEG RAISE |  |  |  |
|  |  |  | KNEE<br>FLEXION 0-130° |  |  |  |
|  |  |  | EXTENSION 130-0° |  |  |  |

|  | LEFT |  |  |  |  | RIGHT |
|---|---|---|---|---|---|---|
|  |  |  | ANKLE<br>DORSIFLEXION 0-20° |  |  |  |
|  |  |  | PLANTARFLEXION 0-45° |  |  |  |
|  |  |  | INVERSION 0-30° |  |  |  |
|  |  |  | EVERSION 0-15° |  |  |  |
|  |  |  | SHOULDER<br>FLEXION 0-180° |  |  |  |
|  |  |  | EXTENSION 180-0° |  |  |  |
|  |  |  | HYPEREXT. 0-15° |  |  |  |
|  |  |  | ABDUCTION 0-180° |  |  |  |
|  |  |  | ADDUCTION 180-0° |  |  |  |
|  |  |  | HORIZ. ABDUCTION 0-90° |  |  |  |
|  |  |  | HORIZ. ADDUCTION 0-45° |  |  |  |
|  |  |  | INT. ROTATION 0-90° |  |  |  |
|  |  |  | EXT. ROTATION 0-90° |  |  |  |
|  |  |  | ELBOW<br>FLEXION 0-145° |  |  |  |
|  |  |  | EXTENSION 145-0° |  |  |  |
|  |  |  | FOREARM<br>SUPINATION 0-90° |  |  |  |
|  |  |  | PRONATION 0-90° |  |  |  |
|  |  |  | WRIST<br>FLEXION 0-90° |  |  |  |
|  |  |  | EXTENSION 0-70° |  |  |  |
|  |  |  | RADIAL DEV. 0-25° |  |  |  |
|  |  |  | ULNAR DEV. 0-55° |  |  |  |
|  |  |  | THUMB<br>MP FLEXION 0-70° |  |  |  |
|  |  |  | MP EXTENSION 70-0° |  |  |  |
|  |  |  | IP FLEXION 0-90° |  |  |  |
|  |  |  | IP EXTENSION 90-0° |  |  |  |

|  | LEFT |  |  |  | RIGHT |  |
|---|---|---|---|---|---|---|
|  |  |  | THUMB (cont'd)<br>IP HYPEREXT. 0-20° |  |  |  |
|  |  |  | ADDUCTION 50-0° |  |  |  |
|  |  |  | ABDUCTION 0-50° |  |  |  |
|  |  |  | OPP. TO BASE 5th DIGIT |  |  |  |
|  |  |  | FINGERS<br>SECOND DIGIT<br>FLEXION MP 0-90° |  |  |  |
|  |  |  | EXTENSION MP 90-0° |  |  |  |
|  |  |  | HYPEREXT. MP 0-30° |  |  |  |
|  |  |  | FLEXION PIP 0-120° |  |  |  |
|  |  |  | EXTENSION PIP 120-0° |  |  |  |
|  |  |  | FLEXION DIP 0-80° |  |  |  |
|  |  |  | EXTENSION DIP 80-0° |  |  |  |
|  |  |  | THIRD DIGIT<br>FLEXION MP 0-90° |  |  |  |
|  |  |  | EXTENSION MP 90-0° |  |  |  |
|  |  |  | HYPEREXT. MP 0-30° |  |  |  |
|  |  |  | FLEXION PIP 0-120° |  |  |  |
|  |  |  | EXTENSION PIP 120-0° |  |  |  |
|  |  |  | FLEXION DIP 0-80° |  |  |  |
|  |  |  | EXTENSION DIP 80-0° |  |  |  |
|  |  |  | FOURTH DIGIT<br>FLEXION MP 0-90° |  |  |  |
|  |  |  | EXTENSION MP 90-0° |  |  |  |
|  |  |  | HYPEREXT. MP 0-30° |  |  |  |
|  |  |  | FLEXION PIP 0-120° |  |  |  |
|  |  |  | EXTENSION PIP 120-0° |  |  |  |
|  |  |  | FLEXION DIP 0-80° |  |  |  |
|  |  |  | EXTENSION DIP 80-0° |  |  |  |

|  | LEFT |  |  |  | RIGHT |  |
|---|---|---|---|---|---|---|
|  |  |  | FIFTH DIGIT<br>FLEXION MP 0-90° |  |  |  |
|  |  |  | EXTENSION MP 90-0° |  |  |  |
|  |  |  | HYPEREXT. MP 0-30° |  |  |  |
|  |  |  | FLEXION PIP 0-120° |  |  |  |
|  |  |  | EXTENSION PIP 120-0° |  |  |  |
|  |  |  | FLEXION DIP 0-80° |  |  |  |
|  |  |  | EXTENSION DIP 80-0° |  |  |  |

Adapted from: Harris County Hospital District

REMARKS:

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ______________________

## POSTURE EVALUATION

1. Place a check (✓) by area of deficit
2. Circle L or R
3. Comment section may denote areas of severity

### RIGHT SIDE VIEW

Comments

1. Head

____ Forward ____ Tilted back
____ Torticollis L or R ____ Lacks C curve

2. Shoulders

____ Forward ____ Back

3. Thoracic area

____ Pigeon breast ____ Barrell chest
____ Kyphosis

4. Lumbar area

____ Protruding abdomen
____ Lordosis ____ No curve

5. Pelvis

____ Tilted forward ____ Tilted backward

6. Knees

____ Flexed ____ Hyperextended

### BACK VIEW

1. Head

____ Asymmetry L or R

2. Shoulders

____ High L or R ____ Low L or R
____ Back L or R ____ Forward L or R

3. Scapula

____ Adducted L or R ____ Abducted L or R

4. Pelvis

____ High L or R ____ Low L or R

5. Spinal curve

____ Cervical L or R ____ Lumbar L or R
____ Thoracic L or R

## FRONT VIEW

| | | Comments |
|---|---|---|
| 1. Hips | | |
| ____ Abducted L or R<br>____ Rotated in L or R | ____ Adducted L or R<br>____ Rotated out L or R | |
| 2. Knees | | |
| ____ Knock knees L or R | ____ Bow legs L or R | |
| 3. Ankle | | |
| ____ Supinated L or R | ____ Pronated L or R | |

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ______________________

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## GAIT ANALYSIS

1. Perform gait analysis without bracing or support; use least possible manual support.
2. Place a check (✓) in the appropriate box; if abnormal, identify abnormality.

| | SWING | | | STANCE | | |
|---|---|---|---|---|---|---|
| | Normal | Ab-normal | Comments | Normal | Ab-normal | Comments |
| TRUNK | | | | | | |
| PELVIS | | | | | | |
| HIP | | | | | | |
| KNEE | | | | | | |
| ANKLE | | | | | | |
| TOES | | | | | | |

Stance Ratio
- Equal ☐
- Unequal ☐

Head Control
- Normal ☐
- Extraneous motion ☐
- Abnormal posture ☐

Arm Swing
- Normal ☐
- Diminished ☐
- Absent ☐
  - Flail ☐
  - Flex. Posture ☐
  - Exten. Posture ☐
  - Excessive ☐

Examiner's Signature: ______________________ Date: ______________________

NAME: ______________________________ DATE: ______________________________

BIRTHDATE: ____________________________

## MUSCLE EXAMINATION

| LEFT | | | Examiner's initial<br>Examination date | RIGHT | | |
|---|---|---|---|---|---|---|
| | | | **NECK** | | | |
| | | | Lateral Flexion | | | |
| | | | Flexion | | | |
| | | | Extension | | | |
| | | | **TRUNK** | | | |
| | | | Flexion | | | |
| | | | Rotation | | | |
| | | | Lateral Flexion | | | |
| | | | Extension | | | |
| | | | **HIP** | | | |
| | | | Flexion | | | |
| | | | Extension | | | |
| | | | Abduction | | | |
| | | | Adduction | | | |
| | | | Int. Rotation | | | |
| | | | Ext. Rotation | | | |
| | | | **KNEE** | | | |
| | | | Flexion | | | |
| | | | Extension | | | |
| | | | **ANKLE** | | | |
| | | | Plantar Flexion | | | |
| | | | Dorsal Flexion | | | |
| | | | Inversion | | | |
| | | | Eversion | | | |
| | | | **TOES** | | | |
| | | | Flexion | | | |
| | | | Extension | | | |

KEY:
0 - Absent
1 - Trace function
2 - Poor function
3 - Fair function
4 - Good function
5 - Normal function
SS - Severe spasticity or spasm
MS - Moderate spasticity or spasm
S - Slight spaticity or spasm
C - Contracture

| LEFT |  |  |  |  | RIGHT |  |  |
|---|---|---|---|---|---|---|---|
|  |  |  | **SCAPULA** |  |  |  |  |
|  |  |  | Protraction |  |  |  |  |
|  |  |  | Retraction |  |  |  |  |
|  |  |  | Elevation |  |  |  |  |
|  |  |  | Depression |  |  |  |  |
|  |  |  | **SHOULDER** |  |  |  |  |
|  |  |  | Flexion |  |  |  |  |
|  |  |  | Extension |  |  |  |  |
|  |  |  | Abduction |  |  |  |  |
|  |  |  | Adduction |  |  |  |  |
|  |  |  | Ext. Rotation |  |  |  |  |
|  |  |  | Int. Rotation |  |  |  |  |
|  |  |  | **ELBOW** |  |  |  |  |
|  |  |  | Flexion |  |  |  |  |
|  |  |  | Extension |  |  |  |  |
|  |  |  | **FOREARM** |  |  |  |  |
|  |  |  | Supination |  |  |  |  |
|  |  |  | Pronation |  |  |  |  |
|  |  |  | **WRIST** |  |  |  |  |
|  |  |  | Flexion |  |  |  |  |
|  |  |  | Extension |  |  |  |  |
|  |  |  | Radial Deviation |  |  |  |  |
|  |  |  | Ulnar Deviation |  |  |  |  |
|  |  |  | **FINGERS** |  |  |  |  |
|  |  |  | Flexion | M.P. |  |  |  |
|  |  |  | Flexion | I.P. |  |  |  |
|  |  |  | Extension | M.P. |  |  |  |
|  |  |  | Extension | I.P. |  |  |  |
|  |  |  | Abduction |  |  |  |  |
|  |  |  | Adduction |  |  |  |  |
|  |  |  | **THUMB** |  |  |  |  |
|  |  |  | Flexion | M.P. |  |  |  |
|  |  |  | Flexion | I.P. |  |  |  |
|  |  |  | Extension | M.P. |  |  |  |
|  |  |  | Extension | I.P. |  |  |  |
|  |  |  | Abduction | Radial |  |  |  |
|  |  |  | Abduction | Palmar |  |  |  |
|  |  |  | Adduction |  |  |  |  |
|  |  |  | Oppostion |  |  |  |  |
|  |  |  | **GRASP** |  |  |  |  |
|  |  |  | Pinch (tips of thumb and index finger) |  |  |  |  |
|  |  |  | Lateral pinch (thumb against lateral side index finger) |  |  |  |  |
|  |  |  | 3-Jaw chuck (thumb against index and middle finger) |  |  |  |  |
|  |  |  | Hook (fingers closed in palm and thumb outside fingers) |  |  |  |  |
|  |  |  | Large grasp (fingers, thumb grasped over object) |  |  |  |  |

From: Swedish Medical Center P.T. Department

Signature

Date

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ______________________

KEY: I-Intact; A-Absent; PI-Partially Intact

## SENSORY EVALUATION

| Test | Date | Response | Date | Response |
|---|---|---|---|---|
| A. Proprioception | | | | |
| Lower Extremity | | | | |
| Big toe - Up | | | | |
| - Down | | | | |
| Ankle - Up | | | | |
| - Down | | | | |
| Knee - Flexion | | | | |
| - Extend | | | | |
| Upper Extremity | | | | |
| Wrist - Extend | | | | |
| - Flexion | | | | |
| Elbow - Extend | | | | |
| - Flexion | | | | |
| Thumb - Extend | | | | |
| - Flexion | | | | |
| Index Finger - Flexion | | | | |
| - Extend | | | | |
| 5th Finger - Extend | | | | |
| - Flexion | | | | |

| Test | Date | Response | Date | Response |
|---|---|---|---|---|
| B. **Finger Identification** | | | | |
| Palmar | | | | |
| Dorsal | | | | |
| C. **Stereognosis** | | | | |
| **Object Recognition** | | | | |
| Key | | | | |
| Button | | | | |
| Safety Pin | | | | |
| Cube | | | | |
| Marble | | | | |
| **Shape Recognition** | | | | |
| Circle | | | | |
| Square | | | | |
| Triangle | | | | |
| **Texture** | | | | |
| Rough (Sandpaper) | | | | |
| Smooth (Silk) | | | | |
| Soft (Fur) | | | | |
| **Size Recognition** | | | | |
| Long | | | | |
| Short | | | | |
| Fat | | | | |
| Thin | | | | |

| Te | Date | Response | Date | Response |
|---|---|---|---|---|
| D. Superficial Sensation | | | | |
| Touch - Lower Extremity | | | | |
| - Upper Extremity | | | | |
| Hot and Cold | | | | |
| Wet and Dry | | | | |
| Sharp and Blunt | | | | |
| Localization of Stimulus | | | | |
| E. Graphesthesia | | | | |
| Circle | | | | |
| Vertical | | | | |
| Horizontal | | | | |
| Simultaneous Tactile Discrimination | | | | |
| Right Cheek, Right Arm | | | | |
| Left Cheek, Right Arm | | | | |
| Left Cheek, Left Arm | | | | |
| Right Cheek, Left Arm | | | | |

Signature: ______________________________

Date: ______________________________

NAME: __________ DATE TESTED: __________

BIRTHDATE: __________ SCHOOL: __________

DIAGNOSIS: __________ SURGERY: __________

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## CLINICAL EVALUATION REPORT

Signature __________ Date __________

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NAME: ______________________ DATE: ______________________

Continued

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______________________ ______________________

Signature Date

**TITLE** Prevocational Assessment and Curriculum Guide (PACG)

**AGE** 10 years and up

**PURPOSE**

1) To assess and identify the prevocational training needs of handicapped persons.
2) To analyze behavior and skill deficits in terms of sheltered employment expectations.
3) To prescribe training goals designed to reduce identified deficits.
4) To evaluate client performance by administering the instrument at the beginning of training in order to define appropriate goal areas and then periodically after training has commenced to determine progress towards training goals.

**TIME** Determined by:

a) length of interview with teacher
b) time spent in observation

Scoring - 5 minutes

**SCORES** The tester notes which checks are in the non-shaded area - meaning training in that area is needed. Checks are weighted and scores are added for each category and placed on the profile sheet. This gives a percent of workshop level and visually demonstrates strong and weak areas.

**RELIABILITY** Split half =.92 where 26 teachers tested 179 persons.

**VALIDITY** A survey of 56 supervisors of workshops in 5 Northwest states and a survey of 15 workshops in Kansas. Pearson r = .83. The PACG was derived from those items 85% of those surveyed found important.

**CONTENT/ SUBTESTS** The survey consists of 46 items in nine subcategories:

| | |
|---|---|
| 1) Attendance/Endurance | 3 |
| 2) Independence | 7 |
| 3) Production | 8 |
| 4) Learning | 6 |
| 5) Behavior | 8 |
| 6) Communication | 5 |
| 7) Social Skills | 5 |
| 8) Grooming/Eating | 2 |
| 9) Toileting | 2 |

**NORMS** 179 handicapped persons aged 10-60 years, 86% were under 22 years

| | |
|---|---|
| Profound MR | 70 |
| Severe MR | 79 |
| Moderate MR | 30 |

Many had other disorders -

| | |
|---|---|
| OH | 20.3% |
| MH | 16.2% |
| LD | 10.4% |
| CP | 9.4% |
| Blind | 6.3% |
| Hearing Impaired | 5.7% |
| Deaf | 2.6% |
| Behavior | 27.1% |

| | |
|---|---|
| | All were enrolled in state institutions, community habilitation centers and public schools. |
| COMMENTS | This screener is easy to administer and score. The norm population is very small but the data is useful in programming for deficit areas. This would be very useful for a prevocational class as the IEP is written in.<br>The emphasis is on social aspects of working which are the main reasons for these persons being unable to hold a job. |
| PUBLISHER | Exceptional Education |
| AUTHOR | D. E. Mithaug, D.K. Mar, J. E. Stewart |
| DATE | 1978 |
| REVIEW | Johnson, J. L. - A replication survey of sheltered workshop entry requirements - AAESPH Review 1978 3116-122 |

| | |
|---|---|
| TITLE | Minnesota Rate of Manipulation Test |
| AGE | Adolescent through adulthood. |
| PURPOSE | Selection of applicants for jobs requiring gross arm-hand manipulatory movements. (e.g., assembly line; power laundry, bindery stitching machine, cashiers, basketball player, boxing) |
| TESTING TIME | Each test is timed - may be given as many as 4 test trials after one practice.<br>- 30 minute testing |
| SCORES | Total seconds to do the test = raw score. This is converted to a scale score. Critical scores should be determined by the tester.<br>Scales = %, standard, stanine and verbal |
| RELIABILITY | Varies from .87 to .98 in test/re-test for 4 tests. |
| VALIDITY | Intercorrelations range from .46 to .64 between tests.<br>Between MRMT and Pennsylvania Bi-Manual<br>Work sample .40 to .46 |
| CONTENT/ SUBTESTS | 1) Placing Test - move the blocks from one board to another<br>2) Turning Test - turn the blocks over using both hands<br>3) Displacing Test - move the blocks over 1 space<br>4) One Hand Turning and Placing Test<br>5) Two Hand Turning and Placing Test<br>May be administered to the blind. |
| NORMS | 3000 cases tested by Employment Stabilization Research Institute at the University of Minnesota.<br>- older unemployed people<br>- none on younger people |
| COMMENTS | Norms are very old - need new data.<br>Seems to have good possibilities when used with large groups to get a baseline.<br>Manual easy to read<br>Not hard to learn or score |
| PUBLISHER | American Guidance Service, Inc. |
| AUTHOR | Employment Stabilization Research Institute, University of Minnesota |
| DATE | Originally 1933<br>Newest Manual 1969 |
| REVIEWS | L. F. Schoenfeldt - Associate Professor Psychology, University of Georgia<br>7th Mental Measurements Yearbook |

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ______________________

## SENSORY INTEGRATION EVALUATION

1. Tactile Defensiveness (check when appropriate):

______ negative reaction

______ stimulus reduction

______ withdrawal

______ aggression

______ distractions

______ complaints

______ anxiety

______ increased movement

______ test incompletion

______ other and/or comments:

2. Distractibility:

______ Auditory - attends to other sounds

______ Visual - attends to objects/persons in room other than task at hand

______ Distracted by other test materials

3. Activity Level:

______ Difficulty sitting still

______ Always seems to be on move

______ Runs rather than walks

______ Low frustration tolerance

______ Other:

4. Muscle Tone:

Passive movement of upper extremity

_____ Increased resistance

_____ Normal resistance

_____ Decreased resistance

Passive movement of lower extremity

_____ Increased resistance

_____ Normal resistance

_____ Decreased resistance

Comments:

5. Eye Preference: (circle appropriate one)

| | eye used | | hand used | |
|---|---|---|---|---|
| S's eye through ring of Examiner's fingers | R | L | R | L |
| S's eye through hole in paper | R | L | R | L |
| S's eye through different objects | R | L | R | L |

6. Eye Movements (horizontal, vertical, diagonal: 8-10" away from face):

_____ jerks in vertical plane

_____ jerks at midline

_____ rubs eyes

_____ turns head instead of eyes

_____ negative verbal comments

_____ smooth movements in all directions

_____ other:

7. Ramp Movements:

_____ tremor

_____ jerky (incoordinated)

_____ too fast

_____ too slow

_____ other:

8. Motor Accuracy (separate sheet for testing student):

Dominant hand:

_____ tremor

_____ too fast

_____ too slow

_____ over attention to detail

_____ switches hands

comments regarding postural adaptation:

Comments concerning grip:

Observations concerning child's vision (i.e. one eys closed, squints, face close to paper, etc.).

9. Draw-A-Person: (Student draws a person on motor accuracy sheet):

Comments concerning observed behaviors:

10. Slosson Drawing Coordination Test:

Comments concerning observed behaviors:

11. Post Rotary Nystagmus:

Left S.D. _____ Time:_______________ Excursion__________

Right S.D. _____ Time: _______________ Excursion__________

Other observed behavior:

12. Imitation of Postures:

Trial: Leaning to right, right palm on cheek, left hand on right elbow, left hand on left hip, right index finger pointed on cheek ___________
right index finger between left middle and left ring ___________
left hand behind left leg, placed on right knee _________________.

Comments (i.e., quickness of assumption, quality, mirror image or exact image of Examiner, etc.):

13. Prone Extension Posture:

_____ unable to assume position

_____ able to assume position, and take resistance

_____ able to assume position and hold against resistance

Comments (i.e. quality of posture assumption, length of time maintained, etc.):

14. Flexed Position Supine:

_____ unable to assume position

_____ able to assume position, unable to take resistance

_____ able to assume position and hold against resistance

Comments (quality of assumption, ability to hold against force):

15. Schilders Arm Extension Test:

Part 1 - Observations (tendency of arms to lower during counting)

Comments:

Part II Observations:

_____ change in arm position

_____ resistance to head turning

_____ loss of equilibrium

_____ negative emotional reactions

Comments:

This test was compiled and adapted from the following references:

Ayres, A.J. Interpreting the Southern California Sensory Integration Tests. Los Angeles: Western Psychological Services.

Ayres, A.J. "Southern California Sensory Integration Tests". Los Angeles: Western Psychological Services.

Examiner's Signature

Date

# DIRECTIONS FOR SENSORY INTEGRATION SCREENER

1. Tactile Defensiveness: Observe for adversive responses to certain types of tactile stimuli. Check appropriate behaviors or comment concerning behaviors.

   Negative reaction: A verbal response occurring after tactile stimulation and before next stimulus. A verbal response referring specifically to being touched.

   Stimulus reduction: A physical response by the child providing additional sensory input, in area touched before next stimulus is given; such as rubbing or scratching over area touched.

   Withdrawal: Resisting being touched, withdrawing body parts away from tester.

   Aggression: Physical responses showing aggressive impulses toward tester or test objects.

   Distractions: Verbal statements of physical activity that indicate an attempt to get out of the test situation.

   Complaints: Verbal complaints of somatic origin or environmental factors.

   Anxiety: Verbal statements indicating general anxiety regarding the test situation or anticipation of discomfort prior to being touched.

   Increased movement: Extraneous physical activity during testing (not shifting of weight in chair if overall attention is still on the task).

   Test Incompletion: Due to refusal or physical non-compliance.

2. Distractibility: Observe for auditory or visual distractibility.

3. Activity Level: Observe for listed behaviors, comment concerning other behaviors.

4. Muscle Tone: Flex and extend upper extremities and feel for change in tone. Flex and extend lower extremities and feel for change in tone. Note whether tone is normal, decreased or increased.

5. Eye Preference: Observe which eye the student uses to sight with and also which hand reaches for the object. Allow child to reach for objects in his midline. Child is asked to look at Examiner through a ring the Examiner has made with thumb and index finger which is presented at child's midline. Other objects such as cones and wrapping paper rolls may be used.

6. Eye Movements: Use a pencil or other appropriate object, hold about 8-10 inches from child's eyes. Move the pencil horizontally, diagonally and vertically. Observe for midline problems and other listed behaviors. If child is unable to stabilize head while tracking, the Examiner should then stabilize head. Test without child's glasses.

7. Ramp Movements: (Ability to perform slow motions): The Examiner directs child to "Watch me do this, then do it with me. Don't go too fast, don't go too slow." The Examiner starts with shoulders abducted to 90° and hands touching shoulders. Slowly extend elbows, then flex elbows and return fingertips to touch shoulders.

8. Motor Accuracy: Part 1 - Student is instructed (verbally) to draw a straight line from one dot to the other dot. The Examiner demonstrates with finger on first dot drawing. The student then completes 4 dot-to-dot drawings.

   Part II - Student is then instructed by Examiner to draw a straight line from dot to dot and also to stay within the "pathway". The Examiner may demonstrate with finger during the first item.

   Part III - The student is instructed to trace on top of lines. If he goes off the line, he is to come back on the lines. The student is not allowed to erase or have a second try on any items. Encourage the student to take his time. Observe student's behaviors and check appropriate behaviors and comment.

9. Draw-A-Person: Instruct child to draw a whole person. Do not suggest body parts. The Examiner states "Are you finished?" to terminate drawing. Write observed behaviors during task.

10. Slosson Drawing Coordination Test: Refer to Slosson Manual for directions concerning administration of the test. Write observed behaviors during task.

11. Post-Rotary Nystagmus Test: Refer to manual for directions. Must be given in standardized way to use standardized scores.

12. Imitation of Postures: The Examiner and student sit facing each other in chairs. The Examiner states "you make your arms and hands do the same thing that mine do". The Examiner then assumes the indicated posture. Emphasis is placed on the student assuming the Examiner's mirror image. It is important that the Examiner assume the postures quickly so that the student cannot follow the Examiner's movements as they are made but must plan his movements based on the observed posture of the Examiner. Note under comments observations such as quickness of assumption, quality, mirror image or exact image of Examiner, etc.

13. Prone Extension Posture (Pivot Prone): The Examiner demonstrates position for the student which is to lie prone with arms slightly abducted and elbows semi-flexed, head up, shoulders and legs off the surface while legs are fully extended. The Examiner may put the student in the posture and then have him relax and assume on his own. "The quality of posture assumption and the length of time the child maintained the position enter into the judgment of maturation of his sensorimotor pattern, tendency to lift one portion of the body at a time is considered to be suggestive of poor sensory integration. This prone extension posture is considered to be suggestive of poor sensory integration. This prone extension posture is considered to be based on a vestibular reflex that elicits that position by impulse flow over vestibulospinal track to the extensor muscles. Inability of the student with minimal brain dysfunction to assume the posture is usually interpreted as insufficient vestibular processing and not the poorly inhibited tonic labyrinthine reflex, as previously reported (Ayres, 1972) and as is found frequently in the more severely involved child" (Ayres).

14. Supine Flexion: The Examiner demonstrates position, or puts the student into position. The student then assumes position on his own. Position requires

student to lie supine, flex at all joints (curled up position). Apply force to flexor muscles by pushing against knees, and head simultaneously. Children under 6 are not expected to hold this position against much force. Under comment section, write observations regarding wholeness of assuming position, time held, holding position against force.

15. Schilders Arm Extension Test (AET): This test evaluates degree of integration of postural responses. Part 1 - The Examiner instructs the student in first part of test to stand with feet together, arms straight in 90° shoulder flexion, fingers abducted and eyes closed. Student counts aloud (Examiner may need to count along) to 10 or 20. Counting distracts student's attention from the maintained posture. Arms lowering may indicate a deficit in a mental process which is related to activities of postural mechanisms.

    Part II - The Examiner asks the student to assume same position without counting. The Examiner turns the student's head from side to side noting change in arm position, resistance to head turning, loss of equilibrium or negative emotional reaction (Ayres). Check behaviors and/or write comments.

| | |
|---|---|
| TITLE | Goodenough Draw-A-Man Test |
| AGE | 1 to 13 primarily elementary age |
| PURPOSE | To test conceptual and intellectual maturity<br>May indicate impairment |
| TIME | 5-10 minutes to administer, 2 minutes to score<br>-either in groups or individually |
| LEVEL | Class A - subject cannot be recognized<br>Class B - a recognizable figure is drawn |
| SCORES | Raw scores are converted to a mental age<br>- scores depend on the number of body parts, their position, clarity, and detail<br>- range from 0 to 51 |
| RELIABILITY/ VALIDITY | Test/re-test - .60 to .70<br>Interscorer reliability .80 to .96<br>Correlation with Stanford-Binet .74 |
| CONTENT | Using a standardized instructions, the child is asked to "make a picture of a man" |
| NORMS | 2975 children representative of occupational distribution of the census |
| COMMENTS | This test was developed in 1923 - The Goodenough - Harris test was developed in the 1950's which has more detail in it.<br>Easy to give and score |
| PUBLISHER | Harcourt Brace Jovanovich, Inc. |
| DATE | 1923 |
| REVIEWS | J. A. Dunn, Director, Developmental Systems Division,<br>American Institute for Research, Palo Alto, California<br>7th Mental Measurements Yearbook |

| | |
|---|---|
| TITLE | Slosson Drawing Coordination Test (SDCT) |
| AGES | For Children and Adults |
| PURPOSE | Designed to identify individuals with various forms of brain dysfunction or perceptual disorders where eye-hand coordination is involved.<br>This test may be used as a screener for problems of education, teaching, guidance and counseling. |
| TESTING TIME | 10-15 minutes to administer<br>1-2 minutes to score |
| SCORES | Each drawing is scored either + or -. A raw score is determined by counting all the "-'s". Percentage equivalents are then taken from the tables provided. This is called an accuracy score. Those scoring under 85% should be given indepth neurologicals. |
| RELIABILITY | .96 test/re-test during same sessions.<br>Interscorer reliability - 54% the same on 37 normal 8th graders.<br>- there were 2 accuracy score differences. |
| VALIDITY | Each of the 12 levels were researched and data from Stanford-Binet Form L-M; Gesell, and C. Amatruda were used. |
| CONTENT | 12 figures are to be reproduced 3 times. The figures get progressively more difficult.<br>Children under 5 may use a crayon.<br>The tester is required to copy as many figures as his age (i.e., 5 year old should copy the first 5 figures). This test makes up a crude developmental scale. |
| NORMS | Children from urban/suburban/rural/black/white/indian, a variety of schools in New York.<br>Adults from urban/rural/black/white/vocational rehabilitation/department of education. |
| COMMENTS | Reliability is inflated.<br>Validity is vague.<br>The manual is easy to follow.<br>There are lots of examples and case studies.<br>200 urban and rural, whites and American Indians at nurseries and private schools.<br>It would seem that this test doesn't tell anything different about a child than could be gained from other better standardized tests. It is easy to give and score. |
| PUBLISHER | Western Psychological Services |
| AUTHOR | Richard L. Slosson |
| DATE | 1975 |
| REVIEWS | A. L. Benton, Professor of Neurology and Psychology, University of Iowa<br>J. C. Reed, Associate Professor of Psychology, Tufts University, School of Medicine, Boston, Massachusetts<br>7th Mental Measurements Yearbook |

| | |
|---|---|
| TITLE | Southern California Sensory Integration Test |
| SECTION | a) Space Visualization Test |
| AGE | 4.0 - 10.11 years |
| PURPOSE | The test is intended to require perception of stimuli composed largely of spatial elements including, in the more advanced items, mental manipulation of space or space visualization. |
| TIME | 10-20 minutes |
| SCORES | Accuracy scores are given as well as time adjusted scores. A right-left or contralateral hand score can be used as a clinical observation for hand dominance or how hand usage affects accuracy when crossing midline is or is not required. |
| RELIABILITY | Highest is for 6 to 8 year olds - .72 - .77 |
| CONTENT | 30-3D puzzles consisting of a formboard and 2 blocks |
| NORMS | 840 students aged 4 to 10.11 from the L.A. area |
| COMMENTS | Not reliable for 10 year olds.<br>Impulsive children often score low. |

| | |
|---|---|
| SECTION | b) Figure-Ground Perception |
| AGE | 4.0 - 10.11 years |
| PURPOSE | To assist in the determination of deficits in visual perception which require selection of a foreground figure from a rival background. |
| TIME | 5 - 10 minutes |
| SCORES | The answers are circled and correct scores added. A standard score is then computed. |
| RELIABILITY | .37 - .52 |
| CONTENT | The student has 60 seconds to pick out figures in a picture. There are 16 pictures. |
| COMMENTS | Does not require verbal or fine motor response.<br>Test is vulnerable to anxiety and impulsiveness.<br>Not appropriate for very young. |

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|---|---|
| SECTION | c) Position in Space |
| AGE | 4 to 10-11 years |
| PURPOSE | The Position in Space test was designed to measure the perception of the same form in different orientations. |

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| | c) Position in Space (continued) |
| TIME | 5 to 12 minutes |
| SCORES | Answers are circled; time and accuracy scores are taken into account. Adjusted and standard scores are computed. |
| RELIABILITY | Poor for 4 year olds. |
| CONTENT | There are 30 items consisting of a variety of figures. The student is required to choose the correct answer. Part of the test is timed. |
| COMMENTS | Very specific.<br>Can be verbal or the answer indicated by yes-no. |

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|---|---|
| SECTION | d) Design Copy |
| AGE | 4 - 10 years |
| PURPOSE | Designed to evaluate the child's ability to duplicate a geometric design, using visual-motor perception and hand use. |
| TIME | 15 - 30 minutes to administer |
| RELIABILITY | The design copy test has a relatively high reliability coefficient, between .60 - .89. This test/re-test coefficient of stability was obtained by testing the same child twice with an interval of time between the two tests. However, the time period between tests is not specified. |
| CONTENT | 13 Dot-To-Dot reproductions |
| COMMENTS | Not discriminative at the 4 year level between those with definite perceptual deficits.<br>Vulnerable to invalidation through experience.<br>Inappropriate for students with upper motor neuron dysfunction. |

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|---|---|
| SECTION | e) Motor Accuracy |
| AGE | 4 - 8 years |
| PURPOSE | Reflects dispraxic and incoordination conditions |
| TIME | 5 - 7 minutes |
| SCORES | The amount of pencil line off the printed line is scored and converted to a standard score. |
| CONTENT | Student draws a line on a printed line. This is timed and both hands are tested. |
| COMMENTS | Enables a comparison of both hands. |

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|---|---|
| SECTION | f) Somatosensory Tests |
| AGE | 4 - 8 years |
| PURPOSE | To measure joint position and movement; to measure stereognosis; to measure tactile perception. |
| TIME | 15 - 20 minutes |
| SCORES | Raw and standard scores are documented. |
| CONTENT | Vision is occluded and the student attempts to replicate what the tester does. There are 6 subtests of a somatosensory nature:<br>1) Kinesthesia<br>2) Manual Form Perception<br>3) Finger Identification<br>4) Graphesthesia<br>5) Localization of Tactile Stimulus<br>6) Double Tactile Stimulus |
| COMMENTS | An understanding of simple verbal responses is required. |

| | | |
|---|---|---|
| SECTION | g) Higher Level Tasks | |
| AGE | 4 - 8 years | |
| PURPOSE | Evaluate some of the higher levels of S.I. based on assimilation of sensation from several sensory modalities and requiring greater central nervous system processing. | |
| TIME | 15 - 20 minutes | |
| SCORES | Raw and standard scores are recorded. | |
| RELIABILITY | Test/re-test 5 - 15 days later vary greatly. | |
| CONTENT/ SUBTESTS | 1) Imitation of Postures | 12 items |
| | 2) Crossing Midline of Body | 8 items |
| | 3) Bilateral Motor Coordination | 8 items |
| | 4) Right-Left Discrimination | 10 items |
| | 5) Standing Balance: Eyes open | 2 items |
| | 6) Standing Balance: Eyes closed | 2 items |
| COMMENTS | 5/6 require non-verbal response | |

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|---|---|
| SECTION | h) Post Rotary Nystagmus Test |
| AGE | 5 - 9 years |

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|---|---|
| SECTION | h) Post Rotary Nystagmus Test (continued) |
| PURPOSE | To evaluate and measure the student's response to post rotary nystagmus.<br>To draw inferences about some of the brain's integrative processes.<br>To evaluate some aspects of the vestibular system. |
| TIME | 5 minutes |
| SCORES | Response is timed and standard scores are computed. |
| CONTENT | The student is seated on a special rotary board with the head positioned.<br>The student is spun for 10 revolutions in 20 seconds in each direction. |
| NORMS | 111 boys and 115 girls aged 5 to 9 from S.W. Los Angeles |
| COMMENTS | To be used in conjunction with other tests<br>To be used only after medical background refutes any possibility of seizures.<br>General: No part of the Ayres battery should be used in isolation.<br>No uncertified person will administer the battery for evaluation purposes. |
| PUBLISHER | Western Psychological Corporation |
| AUTHOR | A. J. Ayres, Ph.D. |
| DATE | 1975 |

## PROCEDURES FOR SOUTHERN CALIFORNIA SENSORY INTEGRATION TESTS (SCSIT)

### I. PURPOSE:

The test battery, accompanied by clinical observation, is designed to detect and determine the nature of sensory integrative dysfunction. The tests are specific to evaluation of the somatosensory, vestibular and visual processing mechanisms. THE SCSIT BATTERY IS SUBJECT TO DISTRICT APPROVAL and will be administered only by therapist's certified by the Center for the Study of Sensory Integrative Dysfunction.

### II. UTILIZATION:

For students with learning disabilities where the therapist is in need of more information to program plan.

A. Procedures for referral:

1. Requests for the battery should be made in writing to your program assistant assigned to coordinate these requests.
2. Requests should be made on a Memo and include student's name, school, principal's name, district, age, IQ and reason for request as well as handicapping condition.
3. The program assistant will contact:
    a. Appropriate Harris County Department of Education Coordinator regarding contractual considerations.
    b. Available therapist certified by the Center for the Study of Sensory Integrative Dysfunction.
    c. Principal of the student's home school to request appropriate room and time arrangements for testing.
4. The program assistant will then send a confirmation memo to the referring, as well as testing therapist.

B. Procedures for tester:

1. The program assistant will contact a certified therapist to determine availability for testing.
2. Upon confirmation of the testers availability, a date and time will be identified.
3. The program assistant will contact the school principal to establish room arrangements, date and time.
4. A confirmation memo will be sent to the referring therapist, testing therapist and principal.

5. The tester should plan to complete the test, scoring and write-up within one day.

6. The write-up should be done according to guidelines from the Center for the Study of Sensory Integrative Dysfunction and will be typed on Harris County Department of Education letterhead.

## III. DISPOSITION:

A. The testing therapist turns in the write-up and protocols to the program assistant.

B. The program assistant will review the data and upon approval will submit it to the secretary for typing.

C. The secretary will place the student's HCDE file, including the completed report, into the testing therapist's basked for proofing and signing.

D. The therapist will return the file to the secretary who will distribute:

   1. original and 1 copy to the school district.
   2. 1 copy to the student's HCDE file.
   3. 1 copy to the testing therapist.
   4. 1 copy to the referring therapist.
   5. 1 copy to the physician, if appropriate.

E. All protocols are considered raw data and will be maintained in the student's HCDE file only.

NAME: ______________________ DATE TESTED: ______________________

BIRTHDATE: ______________________

## SENSORY INTEGRATION: REFLEX TEST

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Grading Key: P = Present; A = Absent; O = Obligatory; A = Abnormally Absent;
E = Emerging Response; R = Residual Reflex (may be tonal change only)

| Position | Reflex | | | |
|---|---|---|---|---|
| 4-POINT KNEELING | Asymmetrical Tonic Neck Reflex | Active | Passive | Comments |
| Left | | | | |
| Right | | | | |
| 4-POINT KNEELING | Symmetrical Tonic Neck Reflex | | | |
| Dorsiflexion | | | | |
| Ventroflexion | | | | |

| | | |
|---|---|---|
| 4-POINT KNEELING | Equilibrium | |
| Left | | |
| Right | | |
| SITTING | Equilibrium | |
| Left | | |
| Right | | |
| Backwards | | |

Comments:

| Position | Reflex | | Active | Comments: |
|---|---|---|---|---|
| KNEELING | Equilibrium | | | |
| Forward | | | | |
| Left | | | | |
| Right | | | | |
| HALF-KNEEL | Equilibrium | | | |
| Forward | | | | |
| Left | | | | |
| Right | | | | |
| STANDING | Equilibrium | Balance | | |
| Forward | | | | |
| Left | | | | |
| Right | | | | |
| Backward | | | | |

This test was compiled and adapted from the following references:

Fiorentino, M.R., "Reflex testing methods for evaluation C.N.S. Development." Springfield, Ill. Charles C. Thomas, 1963.

Signature

Date

## SENSORY INTEGRATION REFLEX EVALUATION DIRECTIONS

1. Asymmetrical Tonic Neck Reflex: Four point kneeling: Examiner demonstrates four-point kneel and active head turning to each side. Child is then instructed to imitate the same position and movements. Verbal directions may be given when child is imitating, i.e. turn head to window, turn head to door. Elbows should not be locked into extension but should be slightly flexed while testing active and passive atymmetrical tonic neck reflex. Examiner then passively turns child's head approximately 90 degrees to one side and then the other. Abnormal response after six months of age will elicit extension of limbs on nose side and flexion of limbs on skull side. If no motion occurs, note increase in flexor tone on skull side and extensor tone on nose side.

2. Symmetrical Tonic Neck Reflex: Four point kneeling: Examiner demonstrates four point kneel and active head movement. Child is then instructed to imitate the same position and movements. Verbal directions should be given to clarify desired head movements, i.e. look up at the ceiling, look down at the floor. Elbows should not be locked into extension but should be slightly flexed while testing active and passive symmetrical tonic neck reflex. Examiner then passively flexes and extends child's head. Abnormal response after six months of age will elicit flexor of the arms with head flexion and extension of the arms with dorsiflexion. If no motion occurs, note increase in flexor or extensor tone.

3. Equilibrium - four point kneeling: Examiner instructs child to assume four point kneel. Examiner gradually pushes child sideways at hip and shoulder. Do this to the right and left side. Normal response after eight months of age should elicit righting of head and thorax and extension of arm and leg on raised side when pushed sideways.

4. Sitting: Examiner instructs student to sit on the floor with knees flexed, feet flat on the floor and arms crossed over his chest. Examiner flexes knees and tilts knees from side to side and backwards. Normal response should elicit head and trunk righting. If student is tilted to far, protective extension will result.

5. Kneeling: Student kneels while Examiner stands behind child and pushes child forward from the shoulder. Normal response should elicit body and head righting. If child is pushed too far, protective extension will follow. Examiner gradually pushes child sideways (right and left side) at the shoulder. Normal response should elicit head and trunk righting and abduction-extension of arm on the raised side. Protective extension on lower side will result if child is pushed too far.

6. Half-Kneel: Examiner instructs student to assume half-kneel position. Student is told that he will be pushed and that he must maintain his balance. Examiner stands behind student and pushes to the sides and forward. Normal response elicits head and trunk righting.

7. Standing: Child is standing. Examiner stands behind child and gently pushes child forward, sideways and backwards, at the shoulders. Normal equilibrium response elicits head and trunk righting. To test balance, Examiner abruptly pushes child forward, sideways and backwards or Examiner stands in front of child

and holds child's hands and pushes and pulls in these directions. Normal response for balance should elicit stepping to follow.

NAME: ______________________________ DATE TESTED: ____________________________

BIRTHDATE: __________________________

## SENSORY INTEGRATION EVALUATION REPORT

"Sensory integration is the ability to take in, sort out and connect information from the world around us. This process is controlled by our Central Nervous System and the information we take in comes through our senses. In normal development, sensory integration functions take place on an automatic level. In other words, you don't have to think about it. A well integrated nervous system is necessry for all of us. Without an efficient nervous system we are not able to interact comfortably with the world around us." (OT Division, Good Samaritan Hospital)

From the data obtained on the Harris County Department of Education Sensory Integration Evaluation, _________________________.
(Student's Name)

______ appears to have significant deficits in sensory integration.

______ appears to have a well integrated sensory integrative system.

______ appears to have some deficits which present an inconclusive picture of his sensory integrative functioning.

INTERPRETATION:

______________________________ ______________________________
Signature Date

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|---|---|
| TITLE | Motor-Free Visual Perception Test (MVPT) |
| AGE | 4 to 9 |
| PURPOSE | Tests visual perception while avoiding motor involvement for screening, diagnostic and research purposes on an individual basis. Areas tested are:<br>1) spatial relationships<br>2) visual discrimination<br>3) figure ground<br>4) visual closure<br>5) visual memory |
| TIME | Untimed but usually takes less than 10 minutes to administer and is very quick to score (2 minutes). |
| SCORES | A raw score is converted to perceptual age (P.A.) and perceptual quotients (P.Q.) |
| RELIABILITY | Test/re-test - 162 children tested 20 days apart .77 to .83.<br>Split-half - Spearman Brown - averaged .88.<br>Kuder Richards - (KR20) .86 average |
| VALIDITY | Content Validity<br>Construct Validity: age differentiation - visual perception increase with age; correlation with similar tests - compared to Frostig .73; internal consistency via item analysis. |
| ONTENT | 36 items of multiple choice are included. The child is required to point to the correct choice of 4 answers. |
| NORMS | 881 normal children aged 4 to 8 from 22 states. This included all races, economic levels, residential areas. |
| COMMENTS | Easy to give and score<br>Manual is well put together<br>Lots of statistical data is available<br>Remedial data is available via the manual<br>Precautions for low scores are emphasized |
| PUBLISHER | Academic Therapy Publication |
| UTHOR | R. P. Colarusso, Ed.D., D. D. Hammill, Ed.D. |
| ATE | 1972 |
| EVIEW | Myers, P.I. Methods for Learning Disorders N.Y. Wiley, 1976 |

| | |
|---|---|
| TITLE | Developmental Test of Visual-Motor Integration (Beery) |
| AGES | 2-8 short form<br>2-15 long form with particular emphasis on pre-school and early primary group. |
| PURPOSE | Visual perception and motor coordination assessment to allow:<br>1) Diagnosis<br>2) Evaluation of deficit areas<br>3) Educational planning specific to the needs of the child<br>4) Bridging the gap between theory and practice in the identification and the remediation of Learning Disorders. |
| TESTING TIME | Not timed<br>Depends upon age of child - up to 20 minutes. 10 minutes for scoring when not familiar with the test - otherwise 2 minutes. |
| LEVELS | None |
| SCORES | Each geometric design is rated either pass or fail.<br>Raw score total is compared to age equivalents. |
| RELIABILITY | Test/re-test - .83 boys, .87 girls |
| VALIDITY | .89 between the VMI and chronological age. |
| CONTENT | 24 geometric forms are to be copied with pencil and paper. The forms get progressively more difficult and should be discontinued when there are 3 consecutive failures. |
| NORMS | 1039 children from Illinois.<br>57% suburban<br>26% urban<br>17% rural<br>no more than 32 children were tested for any age. |
| COMMENTS | Scoring is subjective<br>Manual is scanty on statistical data.<br>Manual has examples of possible ways of drawing the designs.<br>Quick to give. |
| OTHER | Can be used for a group or individual.<br>Good reference and remedial information is included in the manual. |
| PUBLISHER | Follett Publishing Company, Chicago |
| AUTHOR | Keith E. Berry, Ph.D. |
| DATE | 1967 |
| REVIEWS | Brad S. Chissom, Assistant Professor of Education Research<br>Georgia S. College, Georgia - 7th Mental Measurement Yearbook |

| | |
|---|---|
| TITLE | System of Multicultural Pluralistic Assessment (SOMPA) - Physical Dexterity |
| AGE | 5-12 |
| PURPOSE | This test is a small part of a comprehensive battery developed to help overcome cultural biases found in I.Q. testing. It was developed to measure adaptive behavior - required for MR labelling.<br>To provide a set of standardized screening procedures requiring no special equipment and can be administered by trained school personnel to identify high risk children. Tests intactness and capability of the motor and sensory pathways involved in the performance of the exercises. |
| TIME | 20-30 minutes for administration.<br>10 minutes for scoring. |
| SCORES | Raw scores are converted to scaled scores and placed on a % graph which allows easy identification or "At Risk". |
| RELIABILITY | From low .61 to a high of .94 |
| VALIDITY | The items are a collection of "soft signs" used by 2 neurologists, Dr. Leon Gettinger and Dr. Donald Ashburst |
| CONTENT | Battery includes:<br>1) Medical Model - Physical Dexterity.<br>Bender Visual Motor Gestalt<br>Weight by Height, Visual Acuity, Auditory Acuity<br>2) Social System Model - Adaptive Behavior Inventory for Children (ABIC)<br>3) Pluralistic Model - Estimated Learning Potential<br>Sociocultural Scales<br>The exercises for Physical Dexterity include:<br>1) Ambulation<br>2) Equilibrium<br>3) Placement<br>4) Fine motor sequencing<br>5) Finger-tongue dexterity<br>6) Involuntary movement |
| NORMS | 2100 children - random sample representing all the public school children in the State of California |
| COMMENTS | 1) Usefulness in OT - allows the comparison of a high level (L.D.) to a normative population.<br>2) Advantages - standardized scoring and administration<br>no equipment (except tape)<br>quick to administer and score<br>LD and MR children were included in the sample<br>easy to interpret |

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| COMMENTS (cont'd) | 3) Disadvantages - not in depth - only a screening<br>4) Adaptation to other populations - cannot be used with obviously handicapped children<br>5) Manual is easily read - diagrams of the Physical Dexterity tests<br>6) Norm group is very narrow - should be enlarged over a larger geographical area<br>7) Directions are in Spanish and English<br>8) Most tasks are demonstrated to the student<br>9) With observations documented during testing, much more information could be gleaned from it (e.g., dominance, defensiveness) |
| PUBLISHER | Psychological Corporation |
| AUTHOR | Dr. Jane Mercer |
| DATE | 1978 |
| THE SOMPA | A System of Measuring Potential Abilities - 1979 - F. Brown<br>School Psychology Digest - 8 - 37-46<br><br>Is Tissue the Issue? A critic of SOMPA's Models and Tests - 1979<br>J. F. Goodman - School Psychology Digest - 847-70 |

| | |
|---|---|
| TITLE | Balcones Sensory Integration Screener |
| AGE | K - 12 years |
| PURPOSE | To identify students who might benefit from formal sensory motor/sensory integrative testing and programming. |
| TIME | 1/2 hour |
| SCORES | Raw scores are totalled.<br>Raw scores are plotted on the profile sheet to show standard deviation scores. |
| STANDARDIZATION | All subtests were taken from pre-normed data such as:<br>a) Purdue Perceptual Motor Survey<br>b) McCarron Assessment of Neuromuscular Development<br>c) Southern California Sensory Integration Test<br>d) Clinical Neuropsychology: Current Status and Applications<br>e) Reflex Testing Methods for Evaluation CNS Development<br>f) Observation of Clinical Signs<br>g) Essentials of a Neurological Examination<br>The screener was field tests for 2-1/2 years and administered to two first grade classes, two second grade and two third grade classes in two public schools - 130 pupils, aged 6 - 9 years. Racial make up was that of the State of Texas. The items were factor analyzed and eight components defined. |
| CONTENT | Eleven tasks with a variety of items as sub-skills factor into eight components. These are:<br>1) Ocular Motor Control<br>2) Proprioception<br>3) Primitive Reflex-Brain Stem Midline Interaction<br>4) Vestibular<br>5) Tactile Feedback<br>6) Stereognosis<br>7) Form Perception<br>8) Lateralization |
| COMMENTS | Manual is easily understood.<br>More data on reliability/validity is needed.<br>Scoring is easily completed.<br>Profile gives a good "picture" of deficit areas.<br>Dynamometer is not included in the kit. |
| PUBLISHER | Texas Occupational Therapy Association |
| AUTHOR | Cynthia Jones, MS, OTR and Mary Ann Monkhouse, OTR |
| DATE | 1981 |

| | |
|---|---|
| TITLE | Birth to Three Developmental Scale |
| AGE | 0-3 years |
| PURPOSE | For the early identification of developmental delay in:<br>a) oral language i) comprehension ii) expression<br>b) problem solving<br>c) social/personal<br>d) motor<br>To determine strengths and weaknesses for the determination of appropriate educational objectives.<br>To screen normal and gifted below age 3 as well as all handicapped children |
| TIME | 1/2 hour to 1 hour depending upon ease of testing and observation<br>Scoring takes 5 minutes |
| LEVELS | Every 6 months up to 3 years |
| SCORES | Each item is scored + = Pass, ± = Emerging, Fail, Blank = Not observed or refused<br>Credit is given for all consecutive +'s.<br>If there are 2 items per age group - each item scores as 3 months<br>If there are 3 items per age group - each item scores as 2 months<br>This gives the Basal Age.<br>Credit may be given for any + beyond the basal age as "Additional Items"<br>Category age is derived by adding Basal age + Additional Items<br>The subscale scores are plotted on a graph to give a profile of competencies. |
| RELIABILITY | Inter rater - 3 pairs of testers scored protocols for 25 children co efficients ranged from .88 to .99. One of each pair had never used the test before. |
| VALIDITY | The norming population used determined the final 85 items to be used. An 80% cut-off was used to select these items. |
| CONTENT/ SUBTESTS | The test is divided into the 4 sections with score sheets and also a summary page.<br>a) Language Comprehension has a total of 17 items which evaluate awareness and attention to sound, up to comprehension of spoken language. Language expression has a total of 17 items which evaluate pre-linguistic, single and multiple word utterances.<br>b) Problem solving has 18 items which require the child to solve a problem without oral directions nor to give verbal responses.<br>c) Social/Personal - has 16 items including recognition of self and interpersonal relationships. No oral directions or verbal responses are required.<br>d) Motor has 17 items which tap both gross and fine motor skills without oral directions or verbal responses. |

| | |
|---|---|
| NORMS | 357 normal children from age 4-1/2 to 36 months. Children approaching the upper limit for each 6 month level were used. The sample was from California, Tennessee and Utah. There were approximately 20 children per group per age. There was an even distribution between males and females, rural/urban. A variety of ethnic and socio-economic backgrounds were used. |
| COMMENTS | Manual is very clear and easy to follow.<br>Scoring is easy to do.<br>Sometimes a score is on a 1/3 or 1/5 trial basis.<br>Directions are very specific. |
| PUBLISHER | Teaching Resources |
| AUTHOR | Tina A. Bangs, Susan Dodson |
| DATE | 1979 |

| | |
|---|---|
| TITLE | Brigance Diagnostic Inventory of Early Development |
| AGE | 0 - 7 years |
| PURPOSE | Assess performance level<br>I.D. strengths and weaknesses<br>I.D. instructional objectives which are stated measurably and functionally<br>Obtain data to support diagnosis<br>Record keeping tracking system<br>Resource for training parents and others |
| TIME | Varies with the child - about one hour for administration and 10-15 minutes for scoring |
| SCORES | Items are listed with corresponding age equivalents. After each sub group, a graph may be filled in to show the child's functional level. |
| RELIABLITY/ VALIDITY | Criterion referenced |
| CONTENT/ SUBTESTS | This tests 98 skill sequences birth to 7 years in the following areas:<br>1) psychomotor<br>2) self-help<br>3) speech and language<br>4) general knowledge and comprehension<br>5) early academic skills |
| NORMS | The field-test edition was used and critiquedby more than 100 professionals from a wide variety of disciplines in different types of programs in 16 states. |
| COMMENTS | Manual is clear and easily followed and understood but bulky<br>Scoring form is bulky<br>IEP is developed from performance level<br>Easily understood by teachers<br>Does not take into consideration abnormal development |
| PUBLISHER | Curriculum Assoc., Inc. |
| AUTHOR | A. H. Brigance |
| DATE | 1978 |

| | |
|---|---|
| TITLE | Callier - Azusa Scale |
| AGE | 1 month to 108 months |
| PURPOSE | This scale was designed to aid in the assessment of deaf-blind and severely and profoundly handicapped children. The information gathered from this developmental scale allows for the synthesis of developmentally appropriate activities for a child. It can be used to evaluate progress. |
| TESTING TIME | This should be administered after 2 weeks of observation or by a consensus of those people working with the child - preferably in a school/classroom situation. |
| SCORES | The completed step is underlined and the number of the step is ci[illegible] on the scale. The scale then indicates the minimum age equivale[illegible] This is a very rough measure but allows a comparison between subscales. |
| RELIABILITY | Good<br>8 children, and 95 teachers, aides, parents, and specialists at 13 centers in 4 regions participated in the study. Score sheets were completed on each child by 4 observers. Four observers then formed 2 pairs who tested the children again. Correlation coefficients varied between .66 to .97. |
| VALIDITY | 58 deaf-blind children were administered the Callier - Azusa by teachers very familiar with the students and the test. Each child was tested 3 times and an analysis was done. Ability scale coefficients were well above .6. |
| CONTENT/ SUBTESTS | 18 subscales are divided into 5 areas:<br>1) Motor Development<br>2) Perceptual Development<br>3) Daily Living Skills<br>4) Cognition, Communication and Language<br>5) Social Development<br>Each subscale contains a number of sequential steps describing developmental milestones. |
| NORMS | The items are all derived from other test materials based on age equivalents. |
| COMMENTS | Easy to read and score<br>Manual is helpful, stressing precautions<br>Booklet is large and would be unweildy with several students |
| PUBLISHER | University of Texas - Dallas and South Central Regional Center for Services to Deaf-Blind Children, Callier Center for Communication Disorders |
| AUTHOR | R. Stillman, Ph.D. - Editor |
| DATE | 1978 |

**TITLE** Developmental Test of Visual Perception (DTVP - Frostig)

**AGE** 3-6 to 7-11

**PURPOSE** To assess

1) Figure-ground Perception
2) Eye-hand Coordination
3) Form constancy
4) Position in Space
5) Spatial Relationships

**TIME** 1 hour for administration to a group
1/2-3/4 hour for an individual

Scoring 5-10 minutes

**SCORES** Each item is scored 2 (x), 1 (1) or 0 ( ) except for Subtest II which may have a possible high score of 5.

Raw scores per subtest are converted to perceptual age equivalents, scale scores and perceptual quotients. The perceptual quotient can then determine the percentile rank.

**RELIABILITY** Test-retest with a 3 week interval .98 - 1960 study
Test-retest with a 2 week interval .42 - 1961 study
Split half - decreases with age .89 to .78.

**VALIDITY** Compared with the Goodenough .235 for kindergarten
.273 one year later

(Goodenough has a low reliability which would lower the coefficient)

Various studies have been done with control groups which show that all children increase their scores over time but those given perceptual training increase faster.

**CONTENT/ SUBTESTS**

Test 1 - Eye-Motor Coordination - drawing activities including straight, curved and angled lines.

Test 2 - Figure Ground - find the 'hidden' items.

Test 3 - Constancy of Shape - recognize geometric figures.

Test 4 - Position in Space - schematic drawings of common objects are discriminated by rotations and reversals.

Test 5 - Spatial Relationships - copying patterns using dots for guide points.

**NORMS** 2100 children ages 3 to 9 were tested. No blacks and few other minority groups were tested. Most children were from middle class homes and all were from California.

**COMMENTS** To be used as a part of a test battery - not in isolation. Norm group needs to be enlarged and stratified. Manual is easy to follow, very easy to understand due to graphs and pictures. Test is relatively easy to give. Having to use different coloured pencils may confuse some LD testees. More useful and accurate for younger populations. Good predictor of reading readiness. Experienced tester is necessary.

| | |
|---|---|
| PUBLISHER | Western Psychological Service. |
| AUTHOR | Marianne Frostig. |
| DATE | 1963 |
| REVIEWS | B. S. Chissom, Assistant Professor of Educational Research, Georgia Southern College 7th Mental Measurements Yearbook |

| | |
|---|---|
| TITLE | Gesell's Developmental Diagnosis Revised |
| AGE | 0-3 years |
| PURPOSE | To determine the integrity and functional maturity of the child's nervous system. |
| TIME | Depends upon the age and mobility of the child. |
| SCORING | History and observation are very important. A "+" is marked for any behavior that is well established. "+" for incidental or intermediate responses,"-" not present "++" obligatory sequence, "N" no longer necessary, "A" present but abnormal, "D" = disability prevents response, "R" = refusal. General development levels are assigned based on the clustering of scores. A general developmental level is assigned representing the intellectual potential. It is not an average of the 5 areas and is never less than the adaptive level. |
| VALIDITY | Studies were done to determine if the new schedules assigned maturity ages appropriate for chronological ages. If a mean age was statistically outside the 95% confidence limits, the situation was reviewed. Developmental quotients were calculated for maternal education. Results fluctuated. To obviate parents enrolling their children for the study if they were "Very Bright", all infants had to be enrolled below 6 weeks of age. |
| CONTENT/ SUBTEST | Sequences for each of the 8 key zones of 4, 16, 28, 40, 52 weeks and 18, 24, 36 months provide items in the following 5 categories:<br>1) Adaptive Behavior - organization of stimuli- 145 items<br>2) Gross motor behavior - postural reactions, balance-98 items<br>3) Fine motor behavior - hands and fingers in prehension-56 items<br>4) Language behavior - visible and audible communication-109 items<br>5) Personal social behavior - reactions to environment-81 items |
| NORMS | The sample used for the revision was drawn from the Albany area. It was a volunteer population of 233 babies delivered at term, within 2 weeks of expected date of confinement, birth weight of 2500 grams or more; single birth; no abnormalities or developmental delays. All examinations were done between January, 1975 and December 1977 at 4, 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56 weeks and 15, 18, 21, 24, 30, and 36 months. Total number of useable examinations were 927. |

| | |
|---|---|
| COMMENTS | Comprehensive Manual - easy to follow with good diagrams.<br>Useful for young handicapped children.<br>The very early levels are accurate to determine lags, but not for a normal child's development. |
| PUBLISHER | Harper & Row |
| AUTHORS | H. Knobloch; F. Stevens; A. Malone |
| DATE | 1980 |

| | |
|---|---|
| TITLE | Early Identification of Children with Learning Disabilities: The Meeting Street School Screening Test(MSSST) |
| AGE | K - grade 1<br>5 to 7.5 years |
| PURPOSE | To effectively screen early school aged children for potential learning disability.<br>To more clearly understand their visual-perceptual motor, body awareness, control and language difficulties.<br>To observe attention, organization, and carry through. |
| TIME | 15 to 20 minutes. To be individually administered |
| SCORES | Raw scores are totalled from those circled on the score sheets to provide a score for each of the 4 categories. A total raw score is derived by their addition. Converted scale scores are derived for all categories and these are plotted on the Profile Sheet. Cut-off scores of 39 for kindergarten and 55 for grade school are utilized for defining "at risk" students. |
| RELIABILITY/ VALIDITY | Test/re-test with a 2-4 week delay = .85.<br>Compared with ITPA - .77.<br>Compared with Frostig - .57.<br>Predictive validity - Tested in kindergarten plus IQ and compared with achievement scores at the end of Grade 1 - .63. |
| CONTENT/ SUBTESTS | Subtests include:<br>1) Motor Patterning Subtest - gait patterns, hand clapping patterns, direction following, finger touch (29 points).<br>2) Visual-Percetpion - motor match - block tapping - visual matching, visual memory, copy forms, follow directions (30 points)<br>3) Language - repeat words, repeat sentences, counting, tell a story, language sequencing (28½ points). |
| NORMS | Students were tested in Ontario, Massachusetts, Rhode Island, Alabama, and Delaware - All socio-economic levels and races were included. These were for predictive tables.<br>The original norms were from a group of 500 Kindergarten - Grade 1 students representing the socio-economic make-up described by the 1966 U.S. census figures for fathers'occupations. Equal number of boys and girls were used. |
| COMMENTS | Manual has lots of resource data on L.D. observing, assessing, and treating.<br>The test looks relatively easy to give.<br>Longitudinal studies are showing meaningful results. |
| PUBLISHER | Crippled children and Adults of Rhode Island, Inc. |
| AUTHORS | P. K. Hainsworth, M. L. Siqueland |
| DATE | 1968 |

| | |
|---|---|
| TITLE | Purdue Perceptual-Motor Survey |
| AGE | School age - generally grades 2, 3, and 4 |
| PURPOSE | To measure perceptual development in the areas of:<br>) Laterality<br>) Directionality<br>) Perceptual-Motor Match<br>in non-achievers in the classroom |
| TIME | 20 minutes to one hour to administer, 5 minutes to score. |
| RELIABILITY/ VALIDITY | Co-effecient of stability .946 in a test/re-test where the examiners differed in each situation with 30 students who were tested one week apart.<br>Chi-Square Values were computed on each item and they varied greatly. Intercorrelations of items and subtests were done - all are below .40 except chalkboard subtest and rhythmic writing subtest.<br>Concurrent validity = .654 between the test and teacher ratings |
| CONTENT/ SUBTESTS | 22 items include several measures for each of the following:<br>1) Balance and Posture<br>2) Body Image and Differentiation<br>3) Perceptual Motor-Match<br>4) Ocular Control<br>5) Form Perception |
| NORMS | Fifty children were selected from each of the first, second, third, and fourth grades. Two restrictions were made: first, that the child had not been referred to any agency for achievement evaluation; and second, that the child did not have a known motor defect. Once these restrictions were met, all children included in the study were selected from the rosters of the first four grades by the use of a table of random numbers. Each child was administered all thirty items of the survey individually. The examining areas were located in a large library and were sufficiently separated to preclude any copying. Each child participating in the study from the normative group was achieving at least within his assigned grade level. A school serving a wide range of socio-economic groups was chosen. Klondike School, Lafayette, Indiana met the criterion. |
| COMMENTS | Thorough, easily understood manual<br>Pictures of the items are included<br>Scoring is easy to do<br>The summary profile is easy to interpret<br>Validity needs more data |

| | |
|---|---|
| PUBLISHER | C. E. Merrell Publishing Company |
| AUTHORS | E. G. Roach and N. S. Kephart |
| DATE | 1966 |
| REVIEW | C. B. Jamison, Associate Professor of Education, California State College, Los Angeles 7th Mental Measurement Yearbook |

# NOTIFICATION OF COMPLETED OT/PT EVALUATION

TO: ______________________________
(School Personnel)

FROM: ______________________________
(Therapist)

RE: ______________________________ BIRTHDATE: ______________________________
(Student)

SCHOOL: ______________________________ TEACHER'S NAME: ______________________________

DATE: ______________________________

An ___/___ evaluation has been completed. Please set up an ARD/IEP meeting at your
OT PT
convenience.

PARENTS ADDRESS: ______________________________ PHONE #: ______________________________

______________________________

AVAILABLE TIME FOR ARD: ______________________________

## PROCEDURES FOR NOTIFICATION OF COMPLETED OT/PT EVALUATION

I. PURPOSE:

To inform the ARD chairperson that OT/PT Evaluation has been completed.

II. UTILIZATION:

Complete this form after an evaluation has taken place.

III. DISPOSITION:

The therapist will:

A. Send the original to the MDT Leader or the person designated to set up the ARD.

B. Submit a copy to the program assistant with the initial evaluation data.

C. Retain a copy for his/her personal files.

# PROCEDURES FOR IEP UPDATES

## I. PURPOSE

A. This is a means to plan, organize and document therapeutic intervention in relationship to educational goals.

B. Identifies and documents the changing needs of the student in response to treatment on an objective basis.

C. State and federal regulations mandate updating the IEP every 60 school days (e.g., every 3 months).

## II. UTILIZATION

A. The program assistant will supply each therapist with a "Tracking Sheet" with due dates for updating the IEP reports.

B. Short-term goals will be reviewed on the district IEP forms located in the state folder.

C. The therapist will enter the date the current short-term goals were reviewed on the "Tracking Sheet".

D. A copy of the therapist's "Tracking Sheet" will be given to the program assistant in accordance with district procedures to document the date updates have been completed.

## III. DISPOSITION

Updated IEP's are maintained in each student's state audit folder.

## OT/PT (ARD SUMMARY) and (3-YEAR RE-EVALUATION)

ME: ______ D.O.B.: ______ AGE: ______

SCHOOL: ______ AREA: ____ DISTRICT: ______ DATE: ______

GRADE: ______ HANDICAPPING CONDITION: ______ INITIAL EVAL DATE: ______

REFERRING PHYSICIAN: ______
(Name) (Address) (Phone)

CLINIC (if appropriate): ______
(Name) (Address) (Phone)

CONTRAINDICATIONS AND/OR PRECAUTIONS: ______

CASE REVIEW:

| PROBLEMS PREVIOUSLY IDENTIFIED | CURRENT STATUS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

New Problems: ______

CURRENT STRENGTHS:

CURRENT CLASSROOM OBSERVATIONS:

TREATMENT TECHNIQUES UTILIZED AND RESULTS: Attendance _____ out of possible _____ sessions.

EQUIPMENT CURRENTLY UTILIZED:

Equipment: Place Utilized: _____ School _____ Home

HOME/SCHOOL PROGRAM/DIRECTED ACTIVITY PROGRAM:

A Home/School Program/DAP was given to:

_____________ (Name), teacher, on _________ (Date) and was updated on _____________ (Dates).

_____________ (Name), parent/guardian, on _________ (Date) and was updated on _____________ (Dates).

Copies of all Home/School Programs/DAPs are attached.

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services
   _____ should be discontinued.
   _____ should be continued and _____________ (Name) should receive _____________ (Time).
2. Long-Term goals might include: _____________
3. A (home/school program) (directed activity program) will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

Attached (is a/are) (copy/copies) of individual (screening/and/evaluation) report(s).

_____________ Signature(s)/Title(s)

_____________ Date

# PROCEDURES FOR ARD SUMMARY

## I. PURPOSE

A. To summarize the student's progress over the past year as a basis for developing new IEP goals.

B. To provide annual progress report. This will be the only written summary of a student's performance.

## II. UTILIZATION (If the space provided on the ARD Summary Sheets is inadequate, use additional lined paper and paperclip behind the appropriate sheet. DO NOT write on the back of the form.)

A. The "ARD Summary Report" should be written and turned in to the lead therapist prior to the annual ARD.

B. Complete all biographical data.

C. Case Review:

1. Problems Previously Identified:
   list all problems previously identified on the last evaluation or ARD Summary.

2. Current Status:

   a. All students should be screened with the "OT/PT Functional School Screening".

   b. Utilizing the words "Improved", "Unchanged", or "Regressed", give a short statement regarding the student's functional level with an explanation if necessary.

   c. Include problems not previously identified if appropriate.

3. Current Strengths, consider the following:

   a. Social relationships/behavior

   b. Motivation

   c. Sources of support (e.g., teacher, caretaker, family environment)

   d. Physical/mental abilities

4. Current Classroom Observations:

   a. Written in narrative format

   b. Address the demands of the school environment (Refer to "OT/PT Functional School Screening") and the student's ability to cope with them, taking into account strengths and weaknesses addressed above.

5. Treatment Techniques Utilized and Results:
   a. Written in narrative format
   b. Include a statement regarding ARDed treatment time and cumulative attendance. Explain poor attendance if known.
   c. List the type of approach utilized, (e.g., developmental, sensorimotor/neuro developmental, functional/ADL/prevocational).
   d. State the results of the approach and make a recommendation for continuing or changing the treatment approach.
6. Equipment Currently Utilized:
   a. List adapted equipment specifically used by a student.
   b. Check the place the equipment is utilized, (e.g., home, school).
7. Home/School Program/Directed Activity Program-DAP:
   a. Circle appropriate title.
   b. Fill in only the appropriate blanks.
   c. If no program was provided, X through this section (program assistant and typist will know this section was not inadvertently forgotten).
   d. Be sure to attach the original program(s) given to the teacher and/or parent.

D. Recommendations:

1. Complete recommendation #1 by checking the appropriate space. If continued therapy is recommended, complete the student's name and the time suggested.
2. If therapy is indicated, complete recommendation #2 re: Long-Term goals. Long-Term goals should relate to the problems identified earlier in the report.
3. Circle "home/school program" or "directed activity program" if one is provided. X through the item if a program will not be provided.
4. If the standard check-off recommendations are not appropriate and need to be revised; or if they need to be added to, please do so. X through the recommendation section if totally revising or complete the appropriate sections and attach a sheet with new recommendations.
5. Some guidelines when making recommendations might include:
   a. A therapist should make recommendations pertaining to that student's physical needs regarding function within the school setting. It is not the prerogative of the therapist to make recommendations regarding the appropriateness of the school placement.
   b. Decisions regarding the physical placement and special education classification are the responsibility of the ARD Committee and no recommendations addressing these specific areas should be made.

c. When making recommendations re: adapted equipment, the educational relevance of the equipment must be included.

d. As a consultant in a district, unusual recommendations being considered should be discussed verbally with the HCDE program assistant and/or coordinator (e.g., summer program) before the ARD.

e. Any discussion with the parents should include what the therapist can provide within the scope of the educational setting as specified by the ARD committee.

f. When making recommendations for a home program, therapists should keep in mind the constraints of total family needs. The home program should be presented as an option which could augment the school therapy program.

## III. DISPOSITION

A. The therapist submits the "ARD Summary Report" into the lead therapist prior to the ARD. An "OT/PT School Screening" and any individual indepth evaluation(s) which may have been done should also be submitted.

B. The lead therapist will:

1. Review all information.
2. Submit the report for typing when approved or return it to the therapist if corrections are indicated.

C. After typing, the student's HCDE file, including the report (with attached forms) will be placed in the therapist's basket for proofing and signing. Return the file to the secretary who will distribute:

1. original and 1 copy to the school district.
2. 1 copy to student's HCDE file.
3. 1 copy to therapist.
4. 1 copy to the physician, when appropriate.

D. All protocols are considered raw data and will be maintained in the student's HCDE file only.

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713) 692-6216 T6/8-80

PSYCHOLOGICAL SERVICES DIVISION

[✓ OT] PT (ARD SUMMARY) and (3-YEAR RE-EVALUATION)

NAME: Leslie, Lana D.O.B.: 2/21/72 AGE: 8·0

SCHOOL: Park Run Elementary AREA: ____ DISTRICT: Suburban DATE: 10/22/80

GRADE: 1st HANDICAPPING CONDITION: LD

REFERRING PHYSICIAN: Dr. Matthew Burnett (Name) 4006 Montreal Blvd. Houston 77024 (Address) 523-1626 (Phone)

CLINIC (if appropriate): N/a (Name) (Address) (Phone)

CONTRAINDICATIONS AND/OR PRECAUTIONS: n/a

CASE REVIEW:

| PROBLEMS PREVIOUSLY IDENTIFIED | CURRENT STATUS |
|---|---|
| 1. Tactile defensiveness seen as refraining from manipulative tasks, and negative reaction to contact with others. | 1. Improved - she requires less prompting to attend manipulative tasks and group action but still responds somewhat negatively to contact with others. |
| 2. Poor eye tracking ability seen as unable to catch a thrown ball. She is turning head instead of moving her eyes during eye tracking. | 2. Improved - she is able to catch a slowly thrown ball now, however, she still tends to turn her head instead of moving her eyes |

New Problems:

(continued on next page)

CURRENT STRENGTHS:

1. Supportive teacher
2. Improved self-concept
   a. Teacher reports that Lana is participating more in classroom activities
   b. She feels proud of herself because she is now able to copy work off the blackboard.

CURRENT CLASSROOM OBSERVATIONS:

Ms. Atkinson, classroom teacher, reports that Lana's hand writing has improved significantly, however, her hand strength is still weak. Secondly, both P.E. and classroom teacher report that Lana tends to avoid physical nd verbal contact with other children in group activities.

OT ARD Summary re: Leslie, Lana (continued)

| Problems Previously Identified | Current Status |
|---|---|
| | 2. in most eye tracking activities. |
| 3. Poor general strength and balance reactions necessitating stand-by assistance for transfers. | 3. Improved - She is able to do crab-walking for a distance of 20 feet without rest. She is able to do bridging exercises and hold the position for 10 seconds. |

OT/PT ARD Summary Report/2 T6/8-80

TREATMENT TECHNIQUES UTILIZED AND RESULTS: Attendance 61 out of possible 69 sessions.

Lana was ARD'ed for 1 hour of direct therapy per week on 10-8-79. She has missed several sessions due to school absences. The program has been focusing on decreasing her tactile defensiveness, improving eye tracking, balance reactions and general strengthening through neuro-developmental activities. Moderate to significant improvement has been noted in the above areas which enable her to function developmentally at the 4½ year level in gross motor areas and the 6 year level in fine motor areas.

EQUIPMENT CURRENTLY UTILIZED:

Equipment: Place Utilized: ____School ____Home

n/a

HOME/SCHOOL PROGRAM/~~DIRECTED ACTIVITY PROGRAM~~:

A Home/School Program/~~DAP~~ was given to:

Ms. Atkinson (Name), teacher, on 10/21/80 (Date) ~~and was updated on~~ ________ (Dates).

Ms. Leslie (Name), parent/~~guardian~~, on 11/6/79 (Date) and was updated on 3/20/80 & 10/21/80 (Dates)

Copies of all Home/School Programs/~~DAPs~~ are attached.

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services
   ____ should be discontinued.
   ✓ should be continued and Lana (Name) should receive 1 hr/week (Time).
2. Long-Term goals might include: 1. Improve hand strength and finger dexterity for better hand writing and manipulating scissors.
   2. Improve general strength and balance reaction for better participation in PE class.
3. A (home/school program) (~~directed activity program)~~ will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

~~Attached (is a/are) (copy/copies) of individual (screening/and/evaluation) report(s)~~.

Susie Samson, OTR
Signature(s)/Title(s)

10/22/80
Date

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713) 692-6216 T6/8-80

PSYCHOLOGICAL SERVICES DIVISION

[✓ OT/PT] (ARD SUMMARY) and (3-YEAR RE-EVALUATION)

NAME: White, Cheryl D.O.B.: 12/10/69 AGE: 11·3

SCHOOL: West Bay Elementary AREA: — DISTRICT: HCDE DATE: 2/16/81

GRADE: 4th HANDICAPPING CONDITION: PH, OH

REFERRING PHYSICIAN: Dr. Roger Andenburg (Name) 4101 Greenbriar Dr. Houston 77098 (Address) 526-6443 (Phone)

CLINIC (if appropriate): None (Name) (Address) (Phone)

CONTRAINDICATIONS AND/OR PRECAUTIONS: None

CASE REVIEW:

| PROBLEMS PREVIOUSLY IDENTIFIED | CURRENT STATUS |
|---|---|
| 1. Decreased strength in right upper and lower extremities limiting independence around school and during A.P.E. | 1. Improved - Cheryl has demonstrated increased functional strength on the right. |
| 2. Decreased ambulation skills necessitating a buddy system to promote safety. | 2. Improved - Cheryl is able to assume standing independently and can negotiate stairs. |
| 3. Decreased visual perception inhibiting classroom skills. (continued next page) | 3. Improved - Cheryl has accomplished all |

New Problems:

CURRENT STRENGTHS:

1. Pleasant and cooperative for therapy.
2. Motivated to function independently in all areas.
3. Supportive teacher.
4. Supportive parents.
5. Good social skills.
6. High frustration level.

CURRENT CLASSROOM OBSERVATIONS:

Cheryl ambulates within the classroom using her walker and is able to use the restroom independently. Cheryl negotiates ramps, opens doors, and drinks from the water fountain independently using her walker. Ms. Bond, her A.P.E. teacher, states that she prefers the stability of her wheelchair for A.P.E. activities. She utilizes an electric typewriter at school; using a pencil only for circling and underlining. At the present time, she continues to require assistance putting paper in the typewriter and opening her milk. She can

(Continuation Page of OT/PT ARD Summary)

| Problems | Current Status |
|---|---|
| | 3. (continued) of her goals and currently exhibits no functional deficits |
| 4. Decreased ADL's necessitating stand-by assistance from an aide. | 4. Improved - Cheryl is independent in all areas of dressing. She is assisted with opening her milk. |
| 5. Decreased gross motor coordination which decreases independence. | 5. Improved - Cheryl's balance on all 4's and in kneeling position have improved. She can weight-bear for longer periods and is rotating her trunk |
| 6. Decreased fine motor coordination which keeps her behind in class work. | 6. Improved - Left upper extremity<br>Unchanged - Right upper extremity<br>Cheryl's left upper extremity shows improved dexterity and strength. Her right upper extremity remains useful only as an occasional stabilizer and continues to exhibit associated reactions. |

Current Classroom Observations

manage independently once her materials are placed within her reach on the left side. She uses a manual typewriter at home but is expected to receive an electric one in the near future in order to facilitate the speed at which she performs her homework assignments.

**TREATMENT TECHNIQUES UTILIZED AND RESULTS:** Attendance 40 (PT) 34 (OT) out of possible 41 (PT) 35 (OT) sessions.

Cheryl was ARD'ed for 1½ hours of direct physical therapy per week and 1½ hours of direct occupational therapy. She has received a general strengthening and neurodevelopmental approach in therapy and she has shown progress in all areas; consequently, it is recommended that this approach be continued.

**EQUIPMENT CURRENTLY UTILIZED:**

| Equipment: | Place Utilized: School | Home |
|---|---|---|
| Rolling walker | X | X |
| Electric typewriter | X | |
| Bilateral short leg braces | X | X |
| Wheelchair | X | X |

~~HOME/SCHOOL PROGRAM~~/DIRECTED ACTIVITY PROGRAM:

A ~~Home/School Program~~/DAP was given to:

Mrs. Schyder (Name), teacher, on 9/25/80 (Date) and was updated on 2/10/81 (Dates).

Mr. & Mrs. Michael White (Name), parents~~/guardian~~, on 11/79 (Date) and was updated on 9/25/80 and 2/10/81 (Dates).

Copies of all ~~Home/School Programs~~/DAPs are attached.

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services
   ___ should be discontinued.
   X should be continued and Cheryl (Name) should receive 1½ hrs. OT 1 hour PT (Time).
2. Long-Term goals might include: 1. Improve ambulation skills for increased speed & safety between classes.
   2. Increase strength and coordination of all extremities to improve functional ability and manual dexterity at school.
3. A (~~home/school program~~) (directed activity program) will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

~~Attached (is a/are) (copy/copies) of individual (screening/and/evaluation) report(~~s).

Linda Grey, LPT / Susan Sharp, OTR
Signature(s)/Title(s)

February 12, 1981
Date

# PHYSICIAN'S APPROVAL OF ARD/IEP* COMMITTEE MEETING RECOMMENDATION

PHYSICIAN: ______________________________ PHONE: ______________

ADDRESS: ______________________________________________

CLINIC: ______________________________________________

(#) (Address) (Phone)

RE: Occupational and Physical Therapy Services in ______________ Independent School District

STUDENT'S NAME: ______________ ARD/IEP COMMITTEE MEETING DATE: ______________

DATE OF BIRTH: __________ SCHOOL: ______________________ AREA: __________

In order for the student to benefit from instructions at school, the following treatment plan was recommended by a joint committee of parents, school personnel and therapists.

## TREATMENT PLAN

Treatment Time: ______________________________________________

Long-Term Occupational Therapy Goals

Long-Term Physical Therapy Goals

Please sign and return within one week if you agree with the above outlined program. If not in agreement, or for further information please contact ______________ at 691-4521

Therapist's Name

______________

Therapist's Name

Do you wish to receive an annual update from this office? YES_____ NO _____

RETURN ORIGINAL TO HCDE; KEEP COPY FOR YOUR FILES.

______________________ ______________________

Physician's Signature Date

*Admission, Review, Dismissal/Individualized Educational Plan

---

FOR OFFICE USE ONLY:

Date Sent: __________ First Call: __________ Second Call: __________

2nd week (Date) 3rd week (Date)

Return to OT/PT Specialist: __________

4th week (Date)

# PROCEDURES FOR PHYSICIAN'S APPROVAL OF ARD/IEP

## I. PURPOSE:

A. This form documents the physician's approval of the ARD's decision for providing or not providing therapy service.

B. It reconfirms that a doctor is involved with the provision of service.

C. After an annual ARD, this form serves as a new physician's referral.

## II. UTILIZATION:

A. After each ARD, the therapist fills out the form making sure that all NCR copies are legible.

B. If a decision is made on both OT and PT at the ARD, both therapists need to sign the same form.

C. The complet form needs to be given to your secretary for mailing.

D. When it is signed and returned by the physician, a xeroxed copy will be provided to the therapist.

## III. DISPOSITION:

A. Submit all copies into your secretary to be mailed.

B. After the form is signed by the physician and returned to HCDE, the secretary will send:

1. original to the District.
2. 1 copy to the student's HCDE file.
3. 1 copy to the therapist for his/her personal folder.

C. A copy is retained by the physician.

D. If the form is returned unsigned by the doctor, it is referred to the district for followup.

## OT/PT (ARD SUMMARY) and (3-YEAR RE-EVALUATION)

NAME: ______________________ D.O.B.: ____________ AGE: ________

SCHOOL: ________________ AREA: _____ DISTRICT: ____________ DATE: ________

GRADE: ________________ HANDICAPPING CONDITION: ________ INITIAL EVAL DATE: ________

REFERRING PHYSICIAN: ______________________________________________
(Name) (Address) (Phone)

CLINIC (if appropriate): ______________________________________________
(Name) (Address) (Phone)

CONTRAINDICATIONS AND/OR PRECAUTIONS: ______________________________

CASE REVIEW:

| PROBLEMS PREVIOUSLY IDENTIFIED | CURRENT STATUS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

New Problems: ______________________________________________

CURRENT STRENGTHS:

CURRENT CLASSROOM OBSERVATIONS:

TREATMENT TECHNIQUES UTILIZED AND RESULTS: Attendance ____ out of possible _____ sessions.

EQUIPMENT CURRENTLY UTILIZED:

Equipment: Place Utilized: _____School _____Home

HOME/SCHOOL PROGRAM/DIRECTED ACTIVITY PROGRAM:

A Home/School Program/DAP was given to:

__________ (Name), teacher, on __________ (Date) and was updated on __________ (Dates).

__________ (Name), parent/guardian, on __________ (Date) and was updated on __________ (Dates).

Copies of all Home/School Programs/DAPs are attached.

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services
   _____ should be discontinued.
   _____ should be continued and __________ (Name) should receive __________ (Time).
2. Long-Term goals might include: __________
3. A (home/school program) (directed activity program) will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

Attached (is a/are) (copy/copies) of individual (screening/and/evaluation) report(s).

__________ Signature(s)/Title(s) __________ Date

# THREE-YEAR RE-EVALUATION

## I. PURPOSE

1. To comprehensively review the student's level of functioning in the school in compliance with TEA guidelines.
2. To update the student's level of performance through formal documentation.
3. To compare current status with baseline data.

## II. UTILIZATION

Use lined paper for additional space. Do Not write on the back of the form.

A. Biographical Information

1. Put last name first.
2. Circle type of evaluation (3-Year Re-evaluation) and title of the evaluator (OT or PT).
3. Put age in years and months.
4. Specify Elementary - Elem., Junior/Senior High - Jr./Sr. Hi.
5. Date should also include Initial Evaluation Date which needs to be hand written in below DATE: line.
6. Put handicapping condition according to TEA guidelines, not the diagnosis.
7. Complete all other biographical data as requested and mark n/a if the information is not applicable.

B. Case Review

1. By PROBLEMS PREVIOUSLY IDENTIFIED: add (on Initial Evaluation) List all problems identified 3 years ago.
2. Current Status:
    a. Be sure that student being re-evaluated has an OT/PT Functional School Screener.
    b. Use the words "Improved", "Unchanged", or "Regressed" then give a statement regarding the present functional status.
3. New Problems:

    List problems not previously identified that are now apparent.

4. Current Strengths:

   List what you consider to be the positives for the student functionally and environmentally.

5. Current Classroom Observations:
   a. Write in narrative form.
   b. Give a global account of the student as he/she functions in the school environment throughout the day.

6. Treatment Techniques Utilized and Results:
   a. Write in narrative form.
   b. Give attendance as of last ARD date.
   c. Explain poor attendance if known.
   d. List the type of approach utilized, (e.g., developmental, sensorimotor, neurodevelopmental, functional/ADL/prevocational).
   e. State the results of the approach.
   f. List the sources for Re-evaluation (e.g., clinical, self-help, reflex).
   g. Make a recommendation for continuing or changing treatment approach.

7. Equipment Currently Utilized:
   a. List adapted equipment used by the student (e.g., long leg braces, prone stander, wheelchair). Do not list therapy equipment used (e.g., ball, scooter board).
   b. Check the place the equipment is utilized (e.g., home, school).

8. Home/School/Directed Activity Program:
   a. Circle appropriate title.
   b. Only fill in appropriate blanks.
   c. If no program is provided, X through this section.
   d. List dates of the past years' programs only and attach copies.

C. Recommendations

1. Complete #1 by checking the appropriate space.
2. If therapy is indicated, complete #2 long-term goals.
3. Circle by #3 if a program is provided and an X if none is given.

## III. DISPOSITION

A. Submit a report to the lead therapist with all protocol sheets, new parent consent and physician referral (if appropriate).

B. The lead therapist will:

    1. Review all information.

    2. Submit the report to the secretary for typing.

C. The typed report will be placed in the therapist's basket to be proofed, signed, and returned to the secretary.

D. The secretary will track the report and distribute:

    1. Original and 1 copy to the school district.

    2. One copy to student's HCDE file.

    3. One copy to therapist.

    4. One copy to the physician, when appropriate.

E. Protocol sheets are retained at HCDE.

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713) 692-6216 T6/8-80

PSYCHOLOGICAL SERVICES DIVISION

[✓ OT/PT] (ARD SUMMARY) and (3-YEAR RE-EVALUATION)

NAME: Pasternak, Campbell D.O.B.: 8/12/71 AGE: 9·6

SCHOOL: West York Elementary AREA: 8 DISTRICT: Urban DATE: 2/24/82

GRADE: 3rd HANDICAPPING CONDITION: OH Initial Eval. Date: 1/18/79

REFERRING PHYSICIAN: Dr. Henry Clay (Name) 7879 S.W. Freeway #1032 Houston 77074 (Address) 693-4675 (Phone)

CLINIC (if appropriate): none (Name) (Address) (Phone)

CONTRAINDICATIONS AND/OR PRECAUTIONS: none

CASE REVIEW:

| PROBLEMS PREVIOUSLY IDENTIFIED (on initial evaluation) | CURRENT STATUS |
|---|---|
| 1. Decreased range of motion in the trunk and lower extremities resulting in decreased mobility on the school grounds. | 1. Improved - A range of motion evaluation revealed increased hamstring flexibility. Hip extensors and ankle dorsiflexors remain decreased approximately 15°. |
| 2. Increased muscle tone and decreased lower extremity strength causing an abnormal gait. | 2. Improved - On 10/7/80 Campbell underwent bilateral hip adduction transfers, and his "scissoring" |

New Problems: 1. Decreased self-help skills inhibiting independence at school. (to be continued)

CURRENT STRENGTHS:

1. Good attendance
2. Cooperative in therapy
3. Supportive teacher and parents

CURRENT CLASSROOM OBSERVATIONS:

Campbell has a diagnosis of cerebral palsy. He is primarily confined to a wheelchair at school although he spends one hour a day in the standing table in his classroom. According to Mrs. Synder, teacher, Campbell is independent in the class and cafeteria once he is positioned and materials are supplied for him. His independence is limited in regard to mobility. Speech is help downstairs to avoid the stairs. Campbell participates in APE from his wheelchair. He is occasionally inattentive to tasks, but is cooperative in the classroom and during therapy.

| Problems Previously Identified | Current Status |
|---|---|
| | 2. (continued) has decreased significantly. Campbell is currently involved in exercises to normalize tone and strengthen muscle groups. |
| 3. Poorly integrated primitive reflexes necessitating stand-by assistance for most activities. | 3. Slightly improved - A recently administered OT/PT reflex evaluation revealed residual influences of the symmetrical tonic neck, prone tonic labyrinthine and positive supporting. However, the asymmetrical tonic neck reflex has been integrated. |
| 4. Fine motor weakness of both upper extremities hindering desk work in the classroom. | 4. Improved - Campbell's left UE has become more helpful as a stabilizer and gross grasper. His right UE has acquired normal strength and improved manual dexterity. |

TREATMENT TECHNIQUES UTILIZED AND RESULTS: Attendance 28 / 23 out of possible 40 / 45 sessions. OT / PT

Campbell was ARD'ed for 1½ hours per week each of physical and occupational therapy. Absences were largely due to surgery. A general strengthening and gait training approach has been used with emphasis on functional activities. Despite severe post-operative deconditioning, Campbell has made remarkable progress toward achieving pre-operative status in muscle strength. He has recently been re-evaluated using the following tools: Clinical Evaluation, Self-help and Reflex Evaluations. Based on the improvement shown, it is recommended that the above approach be continued.

EQUIPMENT CURRENTLY UTILIZED:

| Equipment: | Place Utilized: School | Home |
|---|---|---|
| Bilateral long leg braces | X | X |
| Standing board | X | |
| Wheelchair | X | X |
| Walker | X | X |

~~HOME/SCHOOL PROGRAM~~/DIRECTED ACTIVITY PROGRAM:

A ~~Home/School Program~~/DAP was given to:

Mrs. Synder (Name), teacher, on 9/24/80 (Date) ~~and was updated on~~ ____ (Dates).

Mrs. Pasternack (Name), parent/~~guardian~~, on 9/24/80 (Date) and was updated on 12/15/80 (Dates).

Copies of all ~~Home/School Programs~~/DAPs are attached.

RECOMMENDATIONS:

1. Based on data available at this time, it is the professional opinion of the examiner(s) that therapy services
   ____ should be discontinued.
   X should be continued and ____ (Name) should receive ____ (Time).
2. Long-Term goals might include: 1. Improve bilateral fine motor skills to enhance table top activities in class 2. Increase functional independence in self-help endeavors 3. Increase gross motor skills necessary for improved ambulation safety on school grounds and in classroom. 4. Improve lower extremity strength and range of motion for improved ambulation with less energy expenditure.
3. A ~~(home/school program)~~ (directed activity program) will be provided.

It is recognized that the decision regarding the provision of specific related services is the responsibility of the ARD Committee.

Attached (is a/[✓ are]) (copy/[✓ copies]) of individual ([✓ screening/and/evaluation]) report(s).

Jack Spratt, OTR / Jenny Lean, LPT
Signature(s)/Title(s)

February 25, 1982
Date

OT/PT SCHEDULE

THERAPIST:______________________________ DATE:__________________________

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 8:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 9:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 9:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 10:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 10:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 11:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 11:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 12:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 12:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 1:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 1:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 2:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 2:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 3:00 | – – – – | – – – – | – – – | – – – – | – – – |
| 3:30 | – – – – | – – – – | – – – | – – – – | – – – |
| 4:00 | – – – – | – – – – | – – – | – – – – | – – – |

## PROCEDURES FOR OT/PT SCHEDULE

### I. PURPOSE

A. To organize the therapist's work day.

B. To enable the HCDE and district staff to contact the therapist(s).

C. To provide accountability to the contracting district.

### II. UTILIZATION

A. Date the schedule in the designated upper right hand corner.

B. Use ink for permanent information.

C. Use pencil for evaluations or awaiting ARD's.

D. Put school in the left upper block and underline the name of the school.

E. Put the school phone # in the right upper block.

F. Put area used for treatment under the school name. If you treat in a different room each time you go to that school, please identify that; otherwise, just list school name on your return visits.

G. List student(s) to correspond to the starting time of treatment session.

H. Put the total number of minutes for treatment, consultation, travel, lunch, etc. in the right bottom corner of that session block.

I. Complete your schedule for an eight hour day. If you do not stay at the last school listed, please put the location and phone # where you can be reached.

J. Keep schedule current. Please call in location changes.

K. All changes must be updated when the therapist is in the office. This includes the date.

### III. DISPOSITION

The therapist gives:

A. The original to the designated secretary.

B. 1 copy to each principal.

C. 1 copy is sent by HCDE to the district contact person.

D. The therapist keeps 1 copy.

# HCDE OT/PT STUDENT ATTENDANCE SHEET

THERAPIST:

STUDENT:

SCHOOL: AREA:

D.O.B.:

CLASSIFICATION:

PARENT:

CONTACT PHONE:

ADDRESS:

M.D. NAME:

CONTACT PHONE:

ADDRESS:

CLINIC NAME:

CONTACT PHONE:

(#)

ADDRESS:

TEACHER'S NAME:

ARD/IEP DATE:

HOME PROGRAM/DAP PROVIDED: NO YES ; DATE(S):

SCHOOL PROGRAM/DAP Provided: NO YES ; DATE(S):

TREATMENT SCHEDULE:

INITIATION OF TREATMENT DATE:

TERMINATION OF TREATMENT DATE:

ATTENDANCE RECORD

SCHOOL YEAR

| MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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CODE: + = Present 0 = Student Absent A= Therapist Absent H = School Holiday
N = Non-Student Day

# PROCEDURES FOR STUDENT ATTENDANCE SHEET

## I. PURPOSE

A. Attendance record for individual treatment and teacher consultation.

B. Quick reference for important data.

C. Record completion form for all students receiving service.

## II. UTILIZATION

The "Student Attendance Sheet" should be filled out on every student ARDed for treatment or consultation.

A. Complete the entire form (excluding "Termination of Treatment Date") to the "Attendance Record" (Information Sources: student's HCDE folder, therapist's personal folder, state audit folder).

B. Use attendance record for documentation of treatment and/or consultation.

C. If an ARD is held during the school year:

1. Beside "ARD/IEP Date", add the date of the most current ARD.
2. Beside "Treatment Schedule", write the current ARD date and the treatment schedule agreed upon in the IEP. If there is no change in the schedule, write "continue".

D. Upon ARD decision to terminate treatment, complete "Termination of Treatment Date" and return "Attendance Sheet" to the designated secretary.

## III. DISPOSITION

Upon termination of services or at the end of the school year the therapist should:

A. Retain a copy for his/her personal folder.

B. Turn in the original and 1 copy to the assistant coordinator/program assistant for distribution as follows:

1. The original to the school district for inclusion in the state audit folder.
2. A copy to the student's HCDE file.

# "HOME/SCHOOL PROGRAM/DIRECTED ACTIVITY PROGRAM(DAP)"

TO: ______________________________ DATE: ______________________
Teacher/Parent

Physical or Occupational Therapy Recommendations for ______________________________
Student's Name

______________________________
(Name of Therapist) (Title)

## PROCEDURES FOR "HOME AND SCHOOL PROGRAM/DIRECTED ACTIVITY PROGRAM (DAP)"

### I. PURPOSE

A. To document and clarify instructions given to the parent or teacher.

B. To maximize the effectiveness of the therapy program.

### II. UTILIZATION

A. Write home/school activities following the designated format below:

  1. Objective of the activity
  2. Description of the activity (include desired response)
  3. Materials utilized

B. When giving a copy to the parent or teacher, provide verbal clarification and demonstration as necessary.

C. Update the program as needed.

### III. DISPOSITION

The therapist will

A. Provide a copy for the teacher or parent.

B. Retain the original and 1 copy in the personal file.

C. The original is ultimately attached to the "OT/PT ARD Summary" to become part of the student's permanent record.

# RECORD OF COMMUNICATIONS

STUDENT:____________________ DOB____________ SCHOOL________________ AREA:______

Please initial after each entry.

| Physician/Parent/Other | Date & Time | Means of Contact | Topic | Discussion/Disposition |
|---|---|---|---|---|
| | | | | |

____________________________

Signature/Title

## PROCEDURES FOR RECORD OF COMMUNICATIONS

### I. PURPOSE

A. Document all communications with physicians and parents.

B. Document communications with others as deemed necessary in the therapist's professional judgement.

### II. UTILIZATION

A. Briefly document appropriate communications.

B. Multiple entries can be made on one form.

C. The therapist should initial each entry.

D. Maintain each form until complete, then place the original in the student's HCDE folder.

### III. DISPOSITION

A. Upon completion of each form or at the end of the school year the therapist:

1. Places original in student's HCDE folder.
2. Maintains the NCR copy in the personal folder.

# HARRIS COUNTY DEPARTMENT OF EDUCATION

PSYCHOLOGICAL SERVICES

T13/8-80

6515 Irvington Boulevard • Houston, Texas 77022 • 713/691-4521

## OCCUPATIONAL THERAPY - PHYSICAL THERAPY NOTES

---

Date

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Date

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Date

---

Date

---

Date

NAME: ______________________ DISTRICT: ______________________ SCHOOL YEAR: ______________________

| School | EVALUATION | | | | Date ARD/ IEP | Copy | | Treatment | First Update | Second Update | Third Update | ARD Summary | | | Sent for typ. | New ARD | Medical Update | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Date of Eval. | Date Rec. | Date Read | Date Sent to Typist | | ✓ ARD | + IEP | | Due | Due | Due | Date | Rec. | Read | | | | |
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# PROCEDURES FOR TRACKING SHEETS

I. PURPOSE

- A. To monitor the flow of paperwork of students referred for therapy service.

II. UTILIZATION

- A. Biographical data
    1. Therapist's name and title (initials).
    2. Specify school district and area if applicable.
    3. Indicate school year.
- B. School
    1. Usually list one school per page.
    2. Enter name of school and note type of school, (e.g., Elem., Jr. Hi., Sr. Hi.).
- C. Students
    1. List students in the "School" column-last name first.
    2. Skip two lines before listing additional student names.
- D. Evaluation
    1. Record the date of evaluation, date received, date read, and date sent to typist in the appropriate columns. (Example #1)
    2. Identify three-year re-evaluations by writing "re-eval" above the date of evaluation (Example #2)
    3. If a report is returned to a therapist for correction, the date sent to the therapist remains blank until the report is approved by the lead therapist and then will be forwarded to the typist. (Example #3)
- E. ARD/IEP
    1. Indicate the date of the ARD/IEP meeting found on ARD forms.
    2. Note the receipt of a copy of information from the ARD meeting with a check (✓) in the "ARD" column. (Appropriate information should include the following: handicapping condition, treatment recommendation, signature page and minutes.)

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E. ARD/IEP (cont'd)

3. Identify the receipt of the student's IEP with a plus sign (+) in the correct column. The IEP contains both long and short term goals.

4. Note the type, amount, and frequency of treatment agreed upon by the ARD Committee in the "Treatment" column.
(Example #1) (Type: D-Direct, C-Consultation)
(Frequency: note treatment/wk. or mo.) (Amount: Use decimal system)

F. Updates

1. Project update dates by utilizing the update schedule.

2. Therapists will indicate when an update has been completed by placing a check (✓) above the appropriate update date. (Example #1)

G. ARD Summary

1. ARD summary reports are coded as described in procedures for recording evaluation reports D. 1 and D. 3. (Example #2)

2. This space can be utilized for recording three-year re-evaluations and end-of-year summary reports (dependent upon district needs). (Example #2)

H. New ARD

1. Indicate the date of the new meeting.

I. Medical Update

1. Indicate the receipt of the signed Physician's Notification of the ARD/IEP meeting by writing the date received in the "Medical Update" column. (Example #1)

2. Suburban district - for special OT cases when a medical is requested (this includes the initial medical), the date received is placed in the "Medical Update" column.

3. For continuous documentation of the progression of a student's therapy program throughout the remainder of the school year, place the date of the new ARD on the following line in the column marked "date ARD/IEP" and provide additional data as needed. (Example #1)

J. Comments

1. Note any specific information pertinent to the student such as: surgery, transfer, move out of the district, discharge, etc. (Example #1)

K. Notations by lead therapists, program assistants and assistant coordinators.

1. The program assistant or assistant coordinator will indicate the need for additional information by placing a circle (in pencil) in the spaces which require the attention of the therapist. (Example #2)

2. When a student has been discontinued from therapy a red line will be drawn through entries pertaining to the student. (Example #1)

K. Notations by program assistants and assistant coordinators (cont'd).

3. Put d/c code in the "Comment" column as follows:
    - a. Independent in the school setting.
    - b. Moved/transferred out of the district or deceased.
    - c. No change in status.
    - d. Changed to homebound.
    - e. Poor attendance.
    - f. Other - please specify.

NAME: Sally Jones, OTR DISTRICT: Suburban SCHOOL YEAR: 81/82

| School | EVALUATION | | | | Date ARD/IEP | Copy | | Treatment | First Update | Second Update | Third Update | ARD Summary | | | Sent for typ. | New ARD | Medical Update | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Date of Eval. | Date Rec. | Date Read | Date Sent to Typist | | ✓ ARD | + IEP | | Due | Due | Due | Date | Rec. | Read | | | | |
| Westhill Elementary | | | | | | | | | | | | | | | | | | |
| Example #1 | | | | | | | | | | | | | | | | | | |
| ~~Smith, Mary~~ | ~~10/10/78~~ | ~~10/13/78~~ | ~~10/20/78~~ | ~~10/29/78~~ | ~~11/3/78~~ | ~~✓~~ | ~~+~~ | ~~D. 1hr/wk.~~ | ~~1/29/79~~ ✓ | ~~4/23/79~~ ✓ | ~~11/3/79~~ ✓ | ~~10/3/79~~ | ~~10/3/79~~ | ~~10/6/79~~ | ~~10/6/79~~ | ~~11/1/79~~ | 12/1/79<br>~~11/15/78~~ | |
| | | | | | 11/1/79 | ✓ | + | D. .5hr/wk. | 1/27/80 ✓ | 4/27/80 | 11/1/80 | 10/9/80 | 10/11/80 | 10/11/80 | 10/11/80 | 11/5/80 | 11/20/80 | ② ~~DC at 11/5/80 ARD~~ |
| | | | | | | | | | | | | | | | | | | |
| Example #2 | | | | | | | | | | | | | | | | | | |
| Doe, Henry | 9/5/78 | | | | 9/15/80 | ✓ | + | D .5hr/wk. | 12/1/80 ✓ | 3/5/81 ✓ | 9/15/81 | 9/5/81 | 9/7/81 | 9/8/81 | 9/8/81 | 9/20/81 | 9/25/80 | |
| | Re-eval<br>9/5/81 | | | | 9/20/81 | ○ | | ○ | 12/6/81 | 3/10/82 | 9/20/82 | | | | | | ○ | |
| | | | | | | | | | | | | | | | | | | |
| Example #3 | | | | | | | | | | | | | | | | | | |
| Jones, Sidney | 9/7/81 | 9/11/81 | 9/13/81 | | | | | | | | | | | | | | | |

HARRIS COUNTY DEPARTMENT OF EDUCATION
MONTHLY SERVICE UPDATE
FOR
INDEPENDENT SCHOOL DISTRICT
OT/PT SERVICES

AREA ______________________

DATE ______________________

| Student | OT PT | Age | School | Handicapping Cond./Grade | | Hours Approved by ARD | | | | Attendance | | ARD | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | OT | | PT | | | | | |
| | | | | | | D | C | D | C | OT | PT | | |
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STATUS FOR MONTH OF ____________

DISTRICT ________________________________

AREA ____________________________________

Total # ARDs: ______

Total # Hours ARDed Consults: ______ OT ______ PT ______

Total # hours ARDed Rx Sessions: ______ OT ______ PT ______

Total # of Evaluations ______ OT ______ PT ______ OT/PT ______

Total # 1x Consults ______ OT ______ PT ______

# of Workshops/Inservice ______ OT ______ PT ______

## PROCEDURES FOR MONTHLY SERVICE UPDATE
## AND
## MONTHLY STATUS REPORT

### I. PURPOSE:

A) To document statistical data on service delivery.
B) To provide data where students are not receiving ARDed treatment time.
C) To provide a compilation of data each month.

### II. UTILIZATION:

A) The lead therapist will be given a folder by the 25th of each month which contains a listing of all students currently ARDed for services.
B) Each therapist is responsible for documenting her caseload.
C) Proof any typed information.
D) Complete School, OT/PT; handicapping condition and grade; attendance.
E) Add any students who have been evaluated and write the amount of evaluation time under attendance.
F) Put a check in the ARD column if you attended an ARD this month.
G) Return to the Lead Therapist who will proof it and compile the information for the Monthly Status Report.

### III. DISPOSITION:

A) The Lead Therapist will turn it into her secretary.
B) The Secretary will Xerox a copy for the District if desired. The original will be filed at HCDE.

## YEAR-END DOCUMENTATION

## I. PURPOSE

A. To provide a comprehensive report of the student's progress during the school year.
B. To provide new therapists with a current view of the student for the next school year.

## II. UTILIZATION:

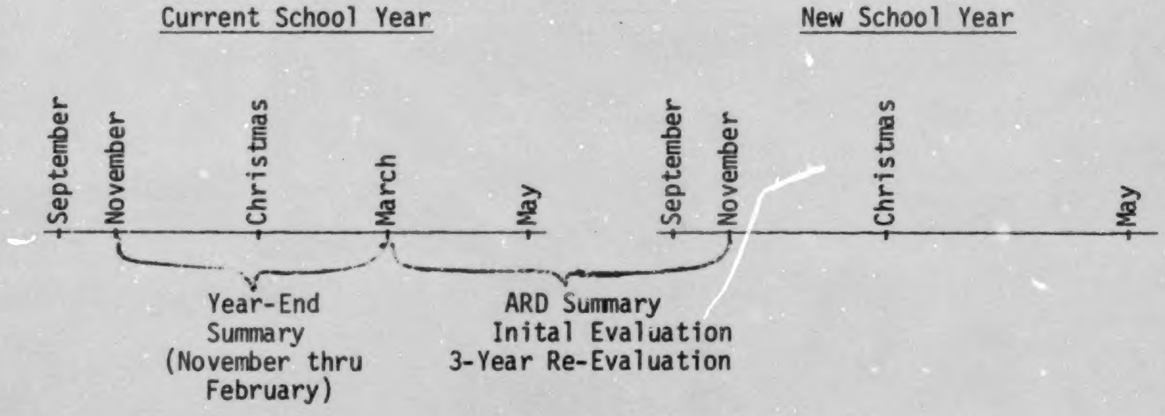
*A. Year-End Summary

1. Write a year-end note on students whose ARD's were held November to March.
2. This note should be written on NCR lined paper.
3. The Year-end Summary should include:
    a. Emphasis of therapy program including goals
    b. Type of treatment and amount of time (individual/group/consult - 1 time/2 times/week)
    c. Attendance
    d. Communications
    e. Current progress of student's abilities (include any surgeries or behaviors)
    f. Recommendations for next school year

*B. ARD Summary

1. Write ARD Summaries on students whose annual ARDs are from March through May or September through October of the new school year.

*NB: No ARD Summary or Year - End note is required if the student has had an Initial Evaluation or 3-Year Re-Evaluation from March through May.


Current School Year
New School Year
September
November
Christmas
March
May
September
November
Christmas
May
Year-End Summary (November thru February)
ARD Summary
Inital Evaluation
3-Year Re-Evaluation

## III. DISPOSITION

### A. Year-End Summary

1. A copy will be sent to the district.
2. A copy will be filed at HCDE.

### B. ARD Summary

1. A copy will be sent to the district.
2. A copy will be filed at HCDE.

# PROCEDURES FOR STUDENT DOCUMENTATION
# AND
# YEAR-END PROCESSING

I. PURPOSE:

- A. To insure accurate coding and recording of student documentation.
- B. To apprise the staff of year-end processing.

II. UTILIZATION:

- A. Student Documentation
  - 1. Initial Evaluation
    - a. When the initial evaluation is completed, turn in parent consent, physician referral (where appropriate), school screener, protocol sheets, and teacher check list if available.
    - b. Attached (if applicable to district) "Notification to District" form.
    - c. Submit completed forms to lead therapist who will proof report and then submit to the secretary for tracking pertinent information and typing.
    - d. Collect the type written report from your basket, proofread and sign.
      - 1) If corrections are necessary, fill out a correction memo.
      - 2) Place the corrected copy in the appropriate basket on the secretary's desk.
    - e. File the typed copy from your basket in the student's personal file.
  - 2. ARD Summary, Year-End Summary and 3-Year Re-Evaluation.
    - a. Write the appropriate report as determined by the district.
    - b. Submit them to the lead therapist for proofing.
    - c. The lead therapist will submit the report to the secretary for tracking.
    - d. These reports will follow the same tracking as the initial evaluations.
  - 3. Up-Dates
    - a. Obtain IEP update dates from your district.
    - b. Therapists will be responsible for informing their assistant coordinator or program assistant of updates that have been completed by marking the tracking sheet with a (✓) over the date.

c. Other relevant information should be recorded at this time to complete the tracking sheet.

4. Monthly Service Updates

a. Therapists are responsible for supplying correct and complete information to the assistant coordinator or program assistant.
b. The lead therapist will complete the Monthly Status Report and bring both the Monthly Service Update and Status Report to the HCDE office.

5. ARD Meetings

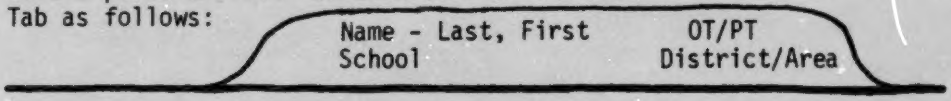
a. After each ARD meeting, the therapist is responsible for submitting a copy of the ARD/IEP forms to her secretary.
b. The following information should be included:

1) Handicapping condition
2) Signature page
3) Recommendation for treatment
4) Long and short=term goals (IEP)
5) Treatment time
6) Minutes (when necessary)

c. The therapist may choose to retain a copy of the ARD/IEP meeting.
d. After the ARD meeting, some districts require that you complete the physician's notification form and submit to your secretary for processing.
e. If the child is ARD'ed for therapy, complete an attendance record form, communication sheet, and therapy note sheet for the student's personal file.

6. Student's Personal File

a. Make a personal file for each current student.
b. Tab as follows:



## III. DISPOSITION:

A. Student Documentation

1. A copy goes to the district.
2. A copy is filed at HCDE.

B. Year-End Procedures

1. Write either an ARD Summary or Year-End Summary
2. Turn in the original communication sheet for HCDE files.
3. Turn in the original attendance sheet and 1 copy.

a. The original goes to the district.
b. The copy is retained at HCDE.

4. Turn in student's personal folders.
    a. Separate the discontinued folders and turn in separately.
5. The following items will be turned in for the summer:
    a. Developmental Kit
    b. Blue Book
    c. Log Procedures
    d. Standardized Equipment
    e. Resource Materials

## OT/PT PACKET OF MATERIALS

NAME: ______________________________ DATE: OUT __________ PACKET # ______________

(Initial) IN __________

A. ______ HCDE Policies Manual (Red Book) S.O.P.

B. ______ TEA Manual

C. ______ OT/PT Forms and Procedures Manual (Blue Book) and log book

D. ______ Personal File Box (Optional)

E. ______ Cardboard Storage Box

F. ______ OT/PT Developmental Evaluation Kit (which includes):

- ______ Wide Mouth Container with the following:
    - 1-Medium Safety Pin
    - 1-Lace for Stringing Beads
    - 5-Large Beads
    - 2-Loose Buttons
    - 5-Pellets
    - 1-Tape Measure
    - 1-Pair of Scissors
    - 10-One Inch Cubes
- ______ Coloring Book
- ______ Picture Book
- ______ 1-Cup with Handle
- ______ Baby Rattle
- ______ 5-Crayons
- ______ Jar with Screw-on Lid
- ______ Set of Nesting Cubes
- ______ Formboard
- ______ Hand Wash
- ______ Mat Wash
- ______ Tea Bell
- ______ Jump Rope
- ______ Nut & Bolt
- ______ Goniometer
- ______ Eye Tracker
- ______ Ziploc Bag Containing:
    - 1-Piece of Silk Fabric
    - 1-Piece of Furry Fabric
    - 10-Wooden Sticks
- ______ Mirror
- ______ Small Nerf Ball
- ______ Large Nerf Ball
- ______ Small Doll
- ______ Pull Toy
- ______ Small Bottle
- ______ All by Himself/Herself or Dressing Doll
- ______ Masking Tape
- ______ Lacing Board
- ______ Bubbles
- ______ Balloons
- ______ 10-Clothes Pegs

## PROCEDURES FOR OT/PT PACKET OF MATERIALS FORM

### I. PURPOSE

A. To document materials which have been signed out to the therapists.

B. To allow therapists to inventory their materials and to turn in completed kits at the year end.

C. To allow for returning and/or replacing misplaced materials based upon the number code.

### II. UTILIZATION

A. This form will be handed out during materials distribution at fall orientation.

B. A number is assigned to each therapist which will appear on all materials signed out to that person.

C. The form will be initialed and dated when materials are distributed and collected.

### III. DISPOSITION

A. Collection of materials will take place during the last week of the school year. At this time, the form is reviewed for completeness.

B. For therapists terminating during the year, the materials form must be completed to administrators satisfaction.

# OCCUPATIONAL/PHYSICAL THERAPY FIELD OBSERVATION FORM

OBSERVATION CODE: ① st time - Black ② nd time - Green ③ rd time - Red

Therapists Name:____________________ Observer(s):____________________

____________________

| DATES | TIME START | TIME FINISH | OBSERVATION SITES |
|---|---|---|---|
| | | | |

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| QUANTITY OF WORK<br>Clinical | ____Consistently unable to deliver service commensurate with the expectations of the district and Harris County Department of Education. (Unable to deliver 6 hours of service or does not meet the child's needs.) | ____Able to deliver an average of 6 hours of service per work day with ease and efficiency.<br>____Performs duties required (Adaptations for school environment, home programs, consultation) | ____Able to deliver 7 hours (or more) of service per work day.<br>____Performs duties beyond those required (equipment consultation, home and summer programs, research). |
| Paperwork | ____Very slow<br>____Needs constant reminders.<br>____Fails to deliver paperwork on time (logs, absence reports, evaluations, summaries, monthly service update. | ____Seldom needs reminders to submit required paperwork.<br>____Monitoring of paperwork required - in on time. | ____Needs no reminders on paperwork requirements.<br>____Anticipates central office needs and promptly submits paperwork. |
| SCORE | | | |

COMMENTS

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| QUALITY OF WORK<br>Clinical | ____ Limited variation on activities/techniques.<br>____ Inappropriate selection of activities/techniques.<br>____ Difficulty establishing long term goals and IEP objectives.<br>____ Lacks awareness of safety procedures<br>____ Demonstrates poor clinical skills | ____ Utilizes varied activities/ techniques.<br>____ Establishes appropriate long term goals and IEP objectives.<br>____ Displays an awareness of safety precautions.<br>____ Demonstrates good clinical skills | ____ Varied and innovative solutions to problems.<br>____ Creative goal setting' activities/IEPs.<br>____ Keen awareness/alertness to safety.<br>____ Demonstrates excellent clinical skills |
| Paperwork | ____ Often unacceptable<br>____ Frequent errors/rejections<br>____ Requires constant supervision<br>____ Poor handwriting<br>____ Grammatical errors | ____ Displays ability to accurately address clinical findings<br>____ Consistent in standards - grammatically correct<br>____ Neat/legible<br>____ Acceptable<br>____ Occasional errors/rejections | ____ Exceptionally accurate<br>____ Practically no errors<br>____ Clear, legible handwriting. |
| SCORE | | | |
| COMMENTS | | | |

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| JOB KNOWLEDGE<br>Clinical | ____Demonstrates limited technical expertise<br>____Fails to observe therapeutic precautions and contraindications.<br>____Unable to select appropriate evaluation tools<br>____Does not seek out information from others<br>____Does not utilize information presented by others. | ____Demonstrates clinical expertise<br>____Utilizes appropriate evaluations<br>____Displays ability to design educationally relevant goals (direct service verses consultation)<br>____Seeks and utilizes information from others<br>____Displays an awareness of precautions. | ____Willing to share information<br>____Gives workshops/inservices<br>____Acts as a resource to peers<br>____Constantly updates clinical skills and knowledge |
| Paperwork | ____Inadequate knowledge of Harris County Department of Education policies and procedures.<br>____Significant difficulty in reporting evaluation results<br>____Experiences difficulty in establishing appropriate goals/ solutions to problems, i.e., treatment recommendation. | ____Displays a working knowledge of Harris County Department of Education policies and procedures.<br>____Able to report clinical observations, evaluations and recommendations in a precise manner. | ____Outstanding knowledge reflected in precise, clearly written reports.<br>____Displays noteworthy expertise. |
| SCORE | | | |

COMMENTS

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| INITIATIVE | ____Needs constant prodding to get the job done.<br>____Rarely volunteers<br>____Fails to communicate with administrative staff. | ____Able to get the job done.<br>____Assesses situations and acts appropriately within the structure set by Harris County Department of Education and the district.<br>____Volunteers occasionally.<br>____Communicates appropriate information to the administrative staff. | ____Seeks leadership.<br>____Volunteers frequently.<br>____Develops and implements new ideas and methods. |
| SCORE | | | |
| COMMENTS | | | |
| ATTITUDE | ____Obstructive<br>____Uncooperative<br>____No enthusiasm.<br>____Not open to constructive feedback. | ____Cooperative<br>____Constructive concerning objectives.<br>____Positive<br>____Realistic<br>____Supportive of HCDE when in the district.<br>____Open to constructive feedback. | ____Demonstrates exceptional skill in fostering good relations with parents, teachers, peers (HCDE/district)<br>____Positive<br>____Enthusiastic<br>____Friendly and assertive. |
| SCORE | | | |
| COMMENTS | | | |

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| TEMPERAMENT | ____Over reacts.<br>____Creates problems by being too emotional, aggressive or withdrawn. | ____Generally even tempered.<br>____Emotional reactions to situations usually are not extreme.<br>____Flexible with changing situations and crises. | ____Confident and assured.<br>____Handles problems calmly and responsibly. |
| SCORE | | | |
| COMMENTS | | | |
| RELATIONS WITH OTHERS | ____Indifferent to the needs of others.<br>____Lack of tact.<br>____Poor ability to communicate.<br>____Unwilling to compromise.<br>____Lacks flexibility.<br>____Unable to establish rapport with students and staff. | ____Generally accepted by others.<br>____Makes needs known tactfully and avoids endangering relationships<br>____Maintains a professional therapeutic relationship with teachers, parents, students, related service personnel.<br>____Displays sensitivity and confidentiality of records and children's rights to privacy.<br>____Able to establish good rapport with the students.<br>____Able to motivate others. | ____Inspires respect and confidence.<br>____Tactful<br>____Thoughtful and considerate.<br>____Understanding<br>____Easily approached for assistance and information.<br>____Promotes enthusiasm with students and staff.<br>____Provides positive reinforcement.<br>____Appropriately solves interpersonal difficulties. |
| SCORE | | | |
| COMMENTS | | | |

| CATEGORY | NEEDS IMPROVEMENT | AVERAGE | ABOVE AVERAGE |
|---|---|---|---|
| ORGANIZATIONAL SKILLS<br>-reports<br>-schedules<br>-logs<br>-information sheets<br>-cancelled treatment time<br>-early dismisal | _____Displays limited skill in meeting time and space requirements.<br>_____Requires help or reminders to get regularly scheduled paperwork finished. | _____Generally meets time and space requirements.<br>_____Can analyze task requirements and meet deadlines - complete tasks.<br>_____Can problem solve for space to work/equipment.<br>_____Good use of related service personnel-involves parents in treatment programs (DAP's).<br>_____Uses spare time effectively. | _____Very effective in managing time and work environment in preparing for task achievement. |
| SCORE | | | |
| COMMENTS | | | |
| OVERALL JOB PERFORMANCE | _____Falls below generally accepted job performance. | _____Acceptable<br>_____Generally exhibits performance normally expected in the responsible professional employee (dress, PR).<br>_____Professional Conduct. | _____Consistently outstanding in performance of job requirements. |
| SCORE | | | |
| COMMENTS | | | |

| | | | |
|---|---|---|---|
| | Date: | Date: | Date: |
| SCHOOL PERSONNEL'S COMMENTS | Name:<br>Title/Position:<br>School: | Name:<br>Title/Position:<br>School: | Name:<br>Title/Position:<br>School: |
| AREAS OF CONCERN THERAPIST/ OBSERVER | | | |
| OVERALL IMPRESSION | | | |

I have had the opportunity to read and discuss this Field Observation Form.

Therapist's Signature ____________ ____________ ____________

Observer's Signature ____________ ____________ ____________

Date ____________ ____________ ____________

# PROCEDURES FOR FIELD OBSERVATIONS FORM

## I. PURPOSE

A. To document therapist strengths and weaknesses as identified by the assistant coordinator/program assistant upon observation of the therapist during the performance of the job.

B. To provide objective information to administration for assistantce in completing annual performance appraisals.

C. To provide constructive feedback to therapists concerning their job performance.

D. To identify personnel with expertise so that they may be used as resource persons for other therapists.

E. To provide therapists with an opportunity to express their feelings and philosophies.

F. To facilitate contact between HCDE and district administrators; thus, ensuring good public relations.

G. To allow therapists to get a feel for what is expected of a staff person at HCDE.

H. To provide administrators with a basis for writing a deficiency plan when necessary.

## II. UTILIZATION

A. This form will be filled out on every therapist at least once during the school year.

B. Multiple visits are recorded on the same form (color coded) and occur at the discretion of the administration. Reasons for multiple field observations include:

1. Therapists' change of setting.
2. Therapists' lack of expertise in a specific area.
3. Therapists' request.
4. Change in performance noted in other areas of work (e.g., paperwork)

C. The report is filled out by the assistant coordinator/program assistant during a minimum two-hour visit. Observations are discussed and agreed upon by both the program assistant/assistant coordinator and therapist and signed by both parties.

## III. DISPOSITION

A. Submitted to coordinator for review - to become part of HCDE's personnel file.

# PERFORMANCE ANALYSIS BY OBJECTIVES

Name: ______________________________

Department: ______________________________

Position: ______________________________

Date: ____________________

| Performance Objectives for 1979-1980 | Planned Activities for Reaching Objectives (Standards) | Actual Results | Explanatory Notes |
|---|---|---|---|
| | | | |

Success Rating:

Signature: Employee ______________________________

Supervisor ______________________________

# PROCEDURES FOR INDIVIDUAL GOAL FORM

## I. PURPOSE

A. To coordinate annual individual goals with those of the Division and HCDE.

B. To promote personal and professional growth in areas the employee and/or assistant coordinator and/or coordinator felt could be further explored.

## II. UTILIZATION

A. This form is to be filled out in the fall after specific information is received from administration.

B. The information is then discussed with the employee's coordinator and/or assistant coordinator and kept in the employee's file.

C. In the spring, the employee notes the results and reviews them with the coordinator and/or assistant coordinator during the performance appraisal interview.

## III. DISPOSITION

A. The form becomes part of the employee's official personnel file.

## EMPLOYEE PERFORMANCE REPORT

NAME (LAST) (FIRST) (MIDDLE) DIVISION

JOB TITLE DATE DIRECTOR

INFORMATION ON THIS FORM SHOULD REFLECT PERFORMANCE
DURING THIS RATING PERIOD ONLY.

PLACE A CHECK ( ) IN THE APPROPRIATE BOX ABOVE STATEMENTS OF PERFORMANCE.

| TRAITS | | | | | | COMMENT(S) |
|---|---|---|---|---|---|---|
| **Quantity of Work:** | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Consider the volume of work | Does not meet requirements of the job, needs improvement | | Good producer, meets standards | | Turns out better than average volume | |
| **Quality of Work:** | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Consider neatness, thoroughness and accuracy of work performed, regardless of quantity | Work careless, frequently incomplete and with many errors | | Nominal errors, generally neat and thorough | | Thorough, outstanding accuracy and neatness | |
| **Job Knowledge:** | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Consider the extent to which the employee possesses the job knowledge necessary to fully perform assigned duties gained through experience, general education and specialized training | Knowledge of job requirements inadequate | | Meets standard of job requirements | | Outstanding knowledge of job assignments | |
| **Initiative:** | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Consider the extent to which the employee is a "self-starter" | Waits for someone else to assume lead in assigned tasks | | Willing to take the lead when required to originate action relative to tasks | | Eagerly seeks out lead in approaching tasks | |
| **Attitude:** | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Consider interest with which work is done, amount of responsibility taken for objectives of the division and job; and efforts to be cooperative. | Little or no concern for objectives of job | | Generally cooperative and constructive concerning accomplishment of objectives | | Outstandingly constructive, eagerly assumes responsibility for attainment of objectives | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Temperament:**<br>Consider emotional make-up and/or behavior pattern | ☐<br>Frequently over reacts; creates problems by being too emotional, aggressive or withdrawn | ☐ | ☐<br>Generally even-tempered; emotional reaction to situations usually not extreme | ☐ | ☐<br>Confident and assured; handles problems calmly and responsibly | |
| **Relations with Others:**<br>Consider personal relationships; communication skills and ability to inspire respect and confidence | ☐<br>Avoided by others; thoughtless and lacking tact | ☐ | ☐<br>Generally accepted by others; listens; makes own needs known tactfully to avoid endangering relationships | ☐ | ☐<br>Highly accepted by others; provides positive reinforcement; appropriately problem solves interpersonal difficulties | (Refers to HCDE as well as ISD's staffs) |
| **Organizational Skills:**<br>Consider the degree to which individual is able to set priorities, complete tasks, manage resources, and meet deadlines | ☐<br>Shows limited skill in meeting time and space requirements | ☐ | ☐<br>Generally meets time & space requirements of the job (can analyze task requirements & meet deadlines & complete tasks) | ☐ | ☐<br>Displays very effective management of time and work environment in preparing for task achievement | |
| **Overall Job Performance:**<br>Consider proficiency with which work assignments have been performed | ☐<br>Falls below generally accepted job performance | ☐ | ☐<br>Acceptable; exhibits performance normally expected in the responsible employee | ☐ | ☐<br>Consistently outstanding performance of job requirements | |
| **Attendance:**<br>Consider frequency of absences | ☐<br>Frequently absent, often without justification | ☐ | ☐<br>Absent only when justifiable; tries to make-up | ☐ | ☐<br>Rarely absent | |
| **Punctuality:**<br>Consider frequency of times tardy | ☐<br>Frequently late, often with questionable justification | ☐ | ☐<br>Late only in rare instances which appear uncontrollable | ☐ | ☐<br>Almost always punctual | |

**Strengths:**

**Individual:** ______________________________

______________________________

**Job Related:** ______________________________

______________________________

**Areas for further growth:*** ______________________________

______________________________

______________________________

**I can help the employee be more effective by:** ______________________________

______________________________

______________________________

***Plans for further growth and/or remediation will be developed in the employee's Objectives for the next school year.**

**Capacity and ambition for future development**

**Review all the traits you have previously considered and judge employee's capacity and ambition for future development.**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Going backward | Reached limit of development | Continue progress in present position | Capable of more responsibility | Qualified for promotion consideration (without regard for current openings at HCDE) |

**Explanation and Recommendation:** ______________________________

______________________________

______________________________

**Remarks - If in your opinion this rating needs to be explained by reason of unusual or special circumstances, give reason below, or if confidential, in a separate memorandum:**

______________________________

______________________________

______________________________

**Reaction to Rating:**

**(a) Employee's reaction to the review: (Employee should initial appropriate block)**

**Satisfied** ☐ **Indifferent** ☐ **Dissatisfied** ☐

**(b) If dissatisfied, employee may submit written statement to director/assistant superintendent by:**

______________ **(Date)**

**Rated by** ______________________________
**Supervisor** **Signature** **Date**

**Signed by** ______________________________
**Employee** **Name** **Date**

## ANNUAL EMPLOYEE REVIEW

### FEELINGS ABOUT YOUR JOB

1. How do you feel about your job? ____________________

____________________

2. What parts of your job do you consider most important? ____________________

____________________

3. What parts of your job do you find most enjoyable and rewarding? ____________________

____________________

4. What parts of your job do you find least enjoyable and rewarding? ____________________

____________________

### PERFORMANCE OF YOUR WORK

1. What parts of your job do you feel you do particularly well? ____________________

____________________

2. Are there duties and responsibilities which are not clear to you? ____________________

Specify ____________________

3. Where do you feel there is greatest room for improvement in your work? ____________________

____________________

4. What suggestions do you have for making improvements? ____________________

____________________

5. Is supervisory assistance, help and support adequate? __________ Specify __________

____________________

I do my best work when ____________________

____________________

____________________

| | |
|---|---|
| ____________________ | ____________________ |
| Employee's Signature/Date | Employer's Signature/Date |

# PROCEDURES FOR PERFORMANCE APPRAISAL FORM

## I. PURPOSE

A. To give the employee feedback with regard to performance in assignments.

B. To give the employee an opportunity to discuss the past year's work per-performance and feelings about job assignments with administrators.

C. To give the employee an understanding of expectations for the following year.

## II. UTILIZATION

A. This form is completed each spring by the employee's coordinator and/or assistant coordinator.

B. Information from this form can be used in considering an employee for reassignment.

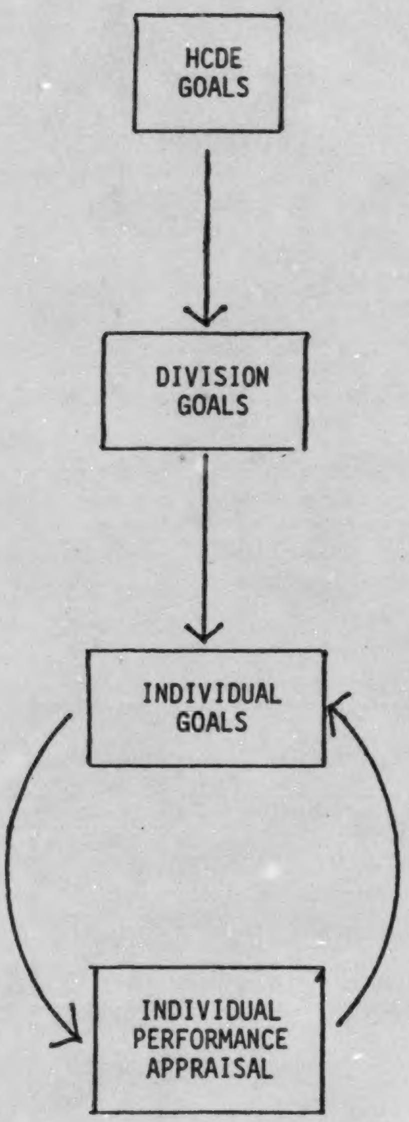
C. Information from this form may be used, with the employee's permission, when recommending the employee for other job settings.

D. The information recorded on this form will be used to develop the employee's individual goals for the following year.

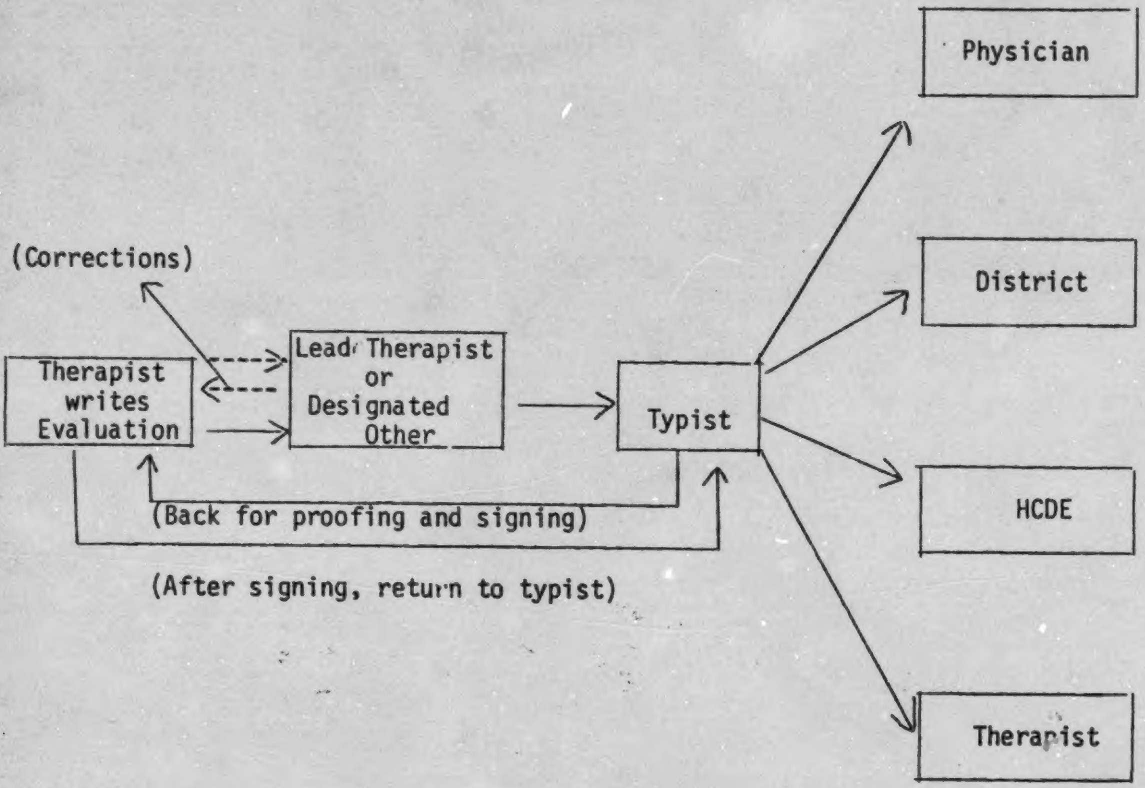
## III. DISPOSITION

A. The form becomes part of the employee's HCDE official personnel file.

HCDE GOAL-SETTING AND PERFORMANCE APPRAISAL


HCDE GOALS
DIVISION GOALS
INDIVIDUAL GOALS
INDIVIDUAL PERFORMANCE APPRAISAL

FLOW CHART


(Corrections)
Therapist writes Evaluation
Lead Therapist or Designated Other
Typist
(Back for proofing and signing)
(After signing, return to typist)
Physician
District
HCDE
Therapist

# LEAD THERAPIST

## AN OVERVIEW OF THE ROLE

The role of the lead therapist has expanded over the past two years. Differences in responsibilities occur from one district to another due to the number of therapists assigned to the district, district needs and therapists needs. Lead therapists are not in a supervisory position but one incurring more administrative duties. The chain of command still applies. The lead therapy position was evolved to expedite matters, not to negate communication between HCDE and therapy staff.

As this position does not include a monetary bonus, Harris County will endeavor to provide an enrichment program geared towards administrative matters in exchange for the added responsibilities and duties which a lead therapist accepts when taking on the job for a year.

# LEAD THERAPIST

## I. PURPOSE

A. To provide consistent communications and facilitate program implementation between the District/Area and the HCDE Administrative office.

B. To provide an opportunity for experienced therapists to utilize their potential leadership abilities and to expand their administrative skills.

## II. UTILIZATION

A. To carry a treatment load commensurate with the expectations of an experienced, organized professional.

B. To function as a liaison between HCDE administrative staff and other therapists assigned to their District/Area.

C. To assist in orienting new staff to the District/Area.

D. To assist in clarifying policies/procedures to staff.

E. To represent and support staff in performing District tasks.

F. To facilitate an organized and coordinated team approach to service delivery.

G. To stimulate further knowledge in specific areas necessary to perform the job well.

H. To expedite reports, referrals, logs, and statistical reports through the HCDE processes.

I. Peer review of reports.

## III. DISPOSITION

A. Lead therapy assignments are re-evaluated each year.

B. A therapist has the option of turning down the position.

C. Administration has the option of asking another therapist to take a turn at the job the following year.

# PROCEDURES FOR PEER REVIEW

## I. PURPOSE

A. To ensure quality in reports being sent to the districts.

B. To speed the process of having reports typed.

C. To enable therapists to profit from seeing the different styles acceptable in writing reports.

D. To ensure therapist's growth in abilities to communicate via report writing.

## II. UTILIZATION

A. The lead therapist will collect all reports from her team.

B. The date the report is received will be written in the upper left hand corner of the report face sheet.

C. The report will be read for the following:

1. All blanks are completely filled in.
2. All appropriate papers are included in the report. (See Procedures for Reports)
3. The documentation supports the recommendations.
4. The doctor's specific orders are addressed.
5. The report is semantically correct, easily followed and understood.

D. The date the report is read is to be placed in the upper right hand corner with a check mark and the initials of the reviewer when it is ready for typing.

E. A therapist on each team will be designated to read the lead therapist's reports, following the same procedures.

## III. DISPOSITION

A. Reports which need further attention should be given back to the therapist with the original of the NCR note attached. The NCR copy should be given to the Program Assistant/Assistant Coordinator.

B. Reports ready for typing should be placed in the designated secretary's basket.

# THREE MODES OF CONSULTATION

| TEACHER CENTERED | STUDENT CENTERED | PROGRAM CENTERED |
|---|---|---|
|  | PURPOSE |  |
| 1. Meets needs of the teacher<br>2. Teacher's problems solved in 1-2 visits | 1. Meets specific needs of student<br>2. Consultation for an individual child | 1. Meets needs of specific programs<br>2. Classroom Consultation (Motor labs/Specialized classes)<br>3. Aids in developing and/or expanding the program<br>4. Modifies existing curriculum |
|  | IMPLEMENTATION |  |
| 1. Possible solutions are discussed with teacher<br>2. Usually no more than 1-2 follow-up visits for 1 specific problem | 1. Therapist demonstrates with the child<br>2. Follow-up on a regular basis<br>3. Hands-on treatment sometimes used by therapist | 1. Therapist outlines the program; teaches it to the implementor<br>2. Therapist updates the program as needed (1 time per week if program is followed daily) |
|  | DOCUMENTATION |  |
| 1. Teacher request for consult<br>2. Tracking sheet | 1. Parent consent<br>2. Dr. referral<br>3. Evaluation<br>4. IEP | 1. Parent consent<br>2. Screening<br>3. Co-sign IEP with teacher |
|  | ADVANTAGES |  |
| 1. No evaluation, committee approval, parent/Dr. permission required<br>2. Intervention can be immediate<br>3. More appropriate referrals | 1. An IEP is required, therapist may co-sign teacher's IEP paperwork<br>2. The therapist is able to closely monitor the student's progress with follow-through by the school staff<br>3. Student usually stays in classroom | 1. The teacher has the IEP responsibility<br>2. The program seems to continue in a more dynamic fasion due to the positive reinforcement provided by the therapist<br>3. The teacher can better organize and implement a program in the future |

## TEACHER CENTERED CONSULTATION

TO: Special Education Teacher

FROM: Director of Special Education

To simplify requests for OT/PT services, teachers may use this form to request therapy consultation regarding student or classroom concerns.

Therapy consultation may be used for any child having difficulty adapting ph[illegible] to normal classroom activities or settings.

1. Fill out teacher request for consultation.
2. Submit to ______________________________.
3. You will be contacted by an OT or PT who is available on alternating Wednesdays.

# TEACHER REQUEST FOR CONSULTATION

Student's Name ____________________ DOB ______________ Age ___________
School ____________________ District ______________ Referral Date _____
Teacher ____________________ Grade ______________
Handicapping Condition ____________________
Problem evident in Classroom ________________________________________
______________________________________________________________
______________________________________________________________

Best time for consultation visit and/or student observation ______ / ______
Time / Day

----------------------------------------------------------------

(To be completed by therapist)

Date referral received ____________________
Contact dates and persons contacted ______________________________
______________________________________________________________
Disposition ______________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
Follow-up _______________________________________________________
______________________________________________________________
______________________________________________________________

# TRACKING SHEET FOR TEACHER-CENTERED CONSULTATIONS

| Name of Student | Name of School | Name of Teacher | Date of Referral | Date of Consultation | Name of Therapist |
|---|---|---|---|---|---|
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## PARENT CONSENT FORM FOR OCCUPATIONAL THERAPY CONSULTATION

I hereby grant permission for my child to have OT classroom consultation. I understand that I will be contacted if any changes are felt necessary in the IEP and I will have the right to give or refuse permission to do so.

____________________________________
Child's Name

____________________________________ ______________________
Signature of Parent/Guardian Date

## PROGRAM-CENTERED CONSULTATION

## OT/PT CLASSROOM OBSERVATION

SCHOOL:

DISTRICT:

CLASSROOM LEVEL:

TEACHER:

DATE OF REFERRAL:

DATE THERAPY STARTED:

AMOUNT OF CONSULTATION GIVEN:

APPROXIMATE TIME:

NUMBER OF STUDENTS:

| STUDENT'S NAME | AGE | MAJOR DISABILITY |
|---|---|---|
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| CLASSROOM THERAPY GOALS | DATE ACHIEVED |
|---|---|
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CYCLE REVIEW DATES

REVISED GOALS

YEAR END REPORT:

ATTENDANCE

| STUDENT | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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CODE: + = Present 0 = Student Absent

Therapist

Date

## PROGRAM-CENTERED CONSULTATION

## DOCUMENTATION FOR REGULARLY SCHEDULED CLASSROOM CONSULTATION

School: ______________________________ Teacher: ______________________________

Date: ______________________________ Therapist: ______________________________

Consultation on the above date was given to the following children:

| Student's Name | Problem and/or Observation | Suggestion Made |
|---|---|---|
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## TRACKING SHEET FOR CLASSROOM CONSULTATION

Name ______________________ District ______________________ School Year ______________________

School ______________________

Teacher ______________________

End of Year Summary

| Date | Rec. | Read | Sent for typing |
|---|---|---|---|
| | | | |

| Students | Date of Referral | Date ARD/IEP | Copy ARD | Copy IEP | OT/PT Screener | Treatment | New ARD | Comments |
|---|---|---|---|---|---|---|---|---|
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## TRACKING SHEET FOR MOTOR LAB

Name ______________________ District ______________________ School Year ______________________

School ______________________

Teacher ______________________

| Students | Date of Referral | Screening | | Treatment | Comments |
|---|---|---|---|---|---|
| | | Pre | Post | | |
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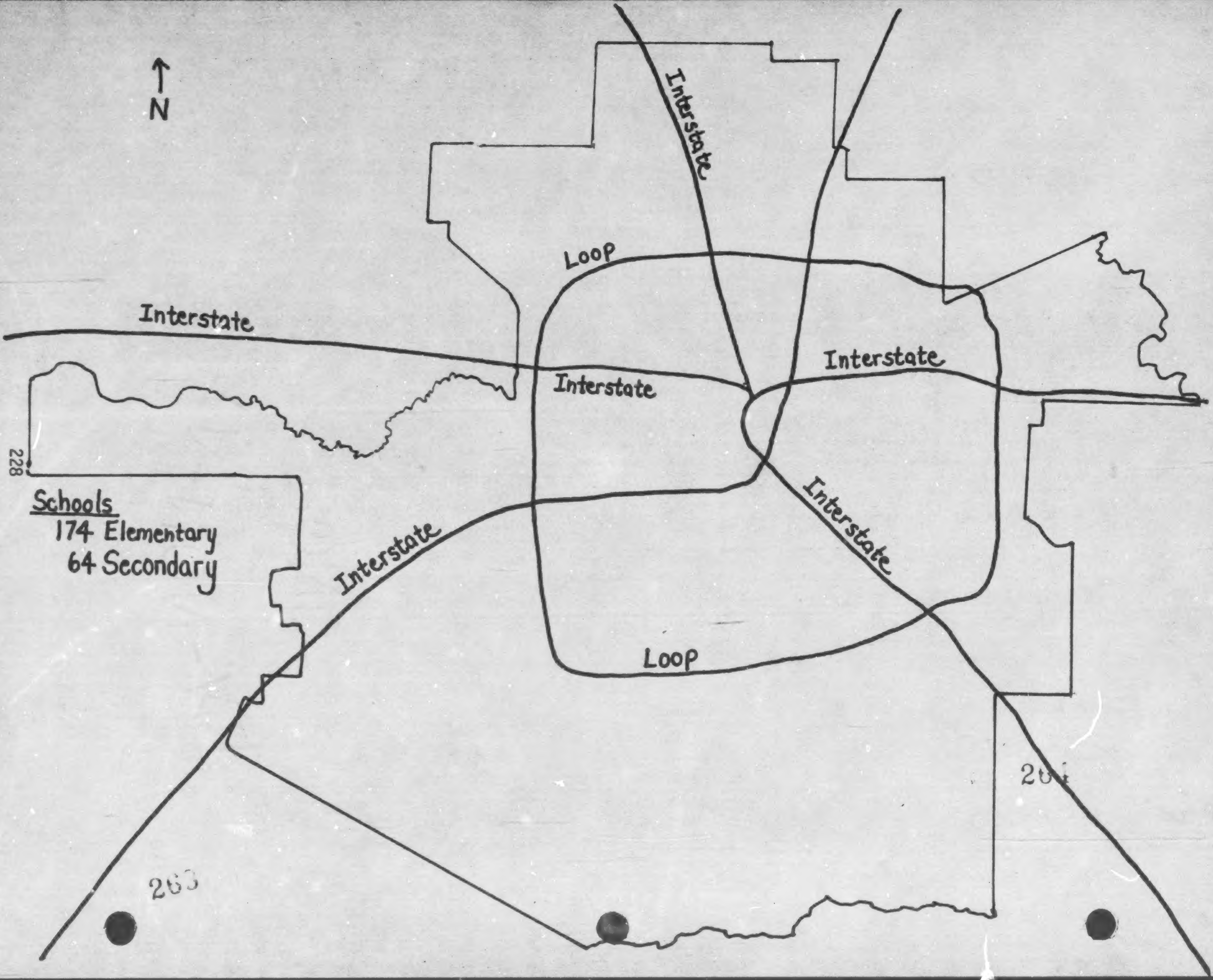
# PART III

## I. URBAN INDEPENDENT SCHOOL DISTRICT POLICY MANUAL: OT/PT PROGRAM

# ABBREVIATIONS

| | |
|---|---|
| A.A.A. | Area Associate Director |
| ARD | Admission, Review and Dismissal |
| ARD/IEP | Admission, Review and Dismissal and/or Individualized Educational Plan |
| HCDE | Harris County Department of Education |
| IEP | Individualized Educational Plan |
| MDT | Multi-Disciplinary Team |
| OT/PT | Occupational and/or Physical Therapy |
| PL 94-142 | Public Law 94-142, "The Education for All Handicapped Children Act" |
| SERS | Special Education Resource Services |
| TEA | Texas Education Agency |
| UISD | Urban Independent School District |


N
Interstate
Interstate
Loop
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228
Schools
174 Elementary
64 Secondary

## INTRODUCTION

The Education for all Handicapped Children Act, Public Law 94-142, enacted by Congress on November 28, 1975 was a landmark legislation assuring a free, appropriate public school education to all handicapped children between the ages of 3-18 by September 1, 1978 and to all those between 3-21 by September 1, 1980.

### Purpose

Section 121a.1 of Public Law 94-142 states the purpose of this act.

1. To insure that all handicapped children have available to them a free appropriate public education which includes special education and related services designed to meet their unique needs.

2. To insure that the rights of handicapped children and their parents are protected.

3. To assist states and localities to provide for the education of all handicapped children.

4. To assess and insure the effectiveness of efforts to educate those children.

### Definition of Related Services

Related services means transportation and such developmental, corrective and other supportive services as they are required to assist a handicapped student to benefit from special education.

### Eligibility

1. The student must be enrolled in special education.

2. The related services traditionally included in the medical model such as occupational therapy and physical therapy may not be delivered without a physician's referral. This referral is maintained in the student's special education state audit folder. A copy of the physician's referral must be given to the therapist(s) prior to evaluation and will be on file at the provider agency.

### Provision of OT/PT Services to the Urban School District

The Urban School District contracts with the provider agency for occupational and physical therapy services for some of the handicapped students who receive these related services. Such services are provided on the basis of time and frequency specified in the individualized educational programs (IEP) developed for each student. When scheduling and facilities permit, these services are delivered where the student attends school; in other instances, students are transported to another site for these services. These services are provided by the school district only when it is substantiated that the student needs such services in order to benefit from instruction.

A student is eligible for services such as OT/PT if the related service is going to assist the student to benefit from special education instruction.

Some therapy services now being offered in the public school system were traditionally offered in the medical setting only. These school related services are not intended to take the place of the primary therapy the student may be receiving in the medical community. Open communication will be maintained with other physicians, therapists, and agencies regarding children they are mutually serving.

The parents' involvement in the student's therapy program is an integral part of the total therapy plan. School services will provide consultation and a written home program which will reinforce and carry over educational and related services.

Only with the mutual sharing of responsibilities among the student, parent educators, physicians, occupational and physical therapist will maximum opportunity to achieve the instructional objectives of the IEP be provided each student.

## OCCUPATIONAL/PHYSICAL THERAPY SERVICES PROVIDED

The following services will be provided.

Direct services

1. Identification through screening
2. Evaluation, monitoring and re-evaluation
3. Treatment planning, both individual and group
4. Treatment implementation in school room, treatment area and home (for homebound students)

Consultation services

1. For the school district
    - Identification of service needs
    - Identification and recommendation for adaptive equipment
    - Identification of architectural barriers
2. For the professional staff
    - Identification of needs and delivery of inservice programs according to the established UISD guidelines
    - Recommendations to integrate therapy techniques into classroom activities
3. For parents
    - Planning, monitoring and modifying home therapy programs
    - Recommendation for modification of home environment and resources to meet needs of student

In addition to job description duties, the Related Service delivery by the professional will include the following:

1. Participate as a member of the Admission, Review and Dismissal team.
2. Review student progress every three months.
3. Participate in the three-year review in related service area.
4. Send teacher's checklist to the referring teacher.
5. Post all referral activity to the tracking sheet.
6. Conduct the initial assessment of each client.
7. Establish specific procedures to meet IEP treatment objectives.
8. Conduct treatment in individual and group sessions.
9. Remediate specific handicapping conditions.
10. Generalize newly-learned behavioral pattern to the classroom situation.
11. Consult with teachers for extending individual programs to the classroom.
12. Consult with parents on student's progress and suggested home program.
13. Provide on-going evaluation and reporting of each student's progress.
14. Participate on panels and in training activities for other professional staff members.
15. Help with inventory care and use of materials purchased for the program.

## PRIORITIES FOR SERVICE

Service will be provided for handicapped students according to the following priorities with the understanding that the most severely handicapped will be served first in each category.

1. Students who have received OT/PT services which are necessary to assist the student to benefit from special education instruction in other facilities.
2. Students presenting current physician's referral for services to assist the student in benefiting from special education instruction.
3. Students who appear to have physical or developmental problems in the classroom which prevent them from benefiting from educational instruction and are referred by teacher, nurse or other significant person.

## REFERRAL PROCESS FOR OT/PT SERVICES

1. The teacher, nurse or other significant person will fill out the provider agency's OT/PT Referral check list (Appendix A1)
2. This form will be channeled through the principal's office to the Multi-Disciplinary Team (M.D.T.) Leader.
3. After the therapist has received the referral form from the M.D.T. Leader, an observation of the student is scheduled.
4. The therapist will fill out an UISD OT/PT data sheet on the referred student. (Appendix A-2)
5. If an evaluation appears to be indicated, the therapist will consult with the area nurse specialist to determine who will take the responsibility for obtaining physician's referral for occupational/physical therapy services and parent consent form. (Appendix A-3-4)
6. The agreed upon professional will consult with the parent to explain the services, deliver information letter to parents and doctor (Appendix A-5), physician's referral for occupational and/or physical therapy services and parent consent form. (Appendix A-3-4)
7. If the services are desired, upon receipt of the signed physician's referral and the parent's consent from the teacher or nurse specialist, the therapist will schedule the evaluation.
8. If the school provided services are not desired by the parents, their rights will be explained and a signed declination of the services (A-6) will be obtained.
9. If the therapist does not feel that the student is an appropriate referral for OT/PT services, a copy of the data sheet with recommendations will be given to the MDT Leader. This report will be included in the MDT Summary. The data sheet will be filed in the student's special education state audit folder.
10. The therapist's recommendation must be considered at the ARD/IEP and formal action must be taken.

# ROLE OF THE PHYSICIAN IN OT/PT SERVICES

Before any handicapped student may receive evaluation and/or other services from occupational and physical therapists, a physician's referral and parent's consent will be necessary.

The student's physician will be informed of the services available (A-5). He will be expected to complete physician's referral (A-3) or submit a written request for services.

Each physician's referral must be written within one calendar year of the scheduled evaluation date, to be considered current and valid.

The physician will receive the copies of the individual evaluation reports (A-8).

The copy of ARD/IEP committee recommendation (A-9) will be forwarded to referring physician for approval.

The physician should review, sign and return the recommendations within one week. If not in agreement, he will contact the therapist immediately.

# THE EVALUATION PROCESS

After the therapist has received the physician's referral and parent consent form, an evaluation date is scheduled as soon as possible.

1. The therapist evaluates, using the appropriate evaluation forms, and writes a summary of evaluation report. After the summary of evaluation report is written, the therapist will complete the notification of completed OT/PT evaluation form (Appendix A-7). This will be given to the multi-disciplinary evaluation team leader serving the school. The area associate director will receive the typed evaluation summary report within ten (10) school days.
2. The multi-disciplinary team leader then works with the parents and the principal to schedule an ARD/IEP meeting.
3. The evaluation protocol will be filed in the student's special education state audit folder at the ARD/IEP meeting.
4. The original and copies of the typed summary of evaluation and suggested goals based on the needs of the student will be mailed from the provider agency to the following:

Original - Area Associate Director
Copy - Director of Health Services
Copy - To referring physician
Copy - Kept on file at provider agency

# ARD/IEP PROCESS

## (ADMISSION, REVIEW, DISMISSAL/INDIVIDUALIZED EDUCATIONAL PROGRAM)

Purpose: The ARD/IEP process, through committee action, determines a student's eligibility for special education and related services, develops an Individualized Educational Plan (IEP), and recommends an appropriate placement in which the student's educational needs might be met.

An ARD/IEP committee is established on each local campus under the direction of the principal to implement the ARD/IEP process. ARD/IEP committees are also established at the Area level under the direction of the Area Associate Director for Special Education and at the central office level under the direction of the Associate Superintendent for Special Education.

The therapist(s) will participate in the ARD/IEP meeting regarding students they have evaluated. Duties of the OT/PT with regard to this committee are as follows:

1. Share the findings of the student's present level of functioning based on evaluation and observations.
2. Make recommendations to the committee regarding their interpretation of the appropriateness of OT and/or PT as related services for the student to benefit from instruction.
3. Present long-term goals that are based on evaluation results and physician's referral (if indicated on the form, Appendix A-3).
4. When developing the IEP, present short-term goals that would work toward achieving the long-term goals. These should be behaviors that can be approximated within 60 days. (State two or three short-term objectives per long-term goal.)
5. When goals have been established the ARD/IEP committee, the therapist will recommend frequency and type of service to be offered (i.e., individual, group or consultation).
6. Provided the ARD/IEP committee approves the therapist's recommendations and physician's referral for therapy is on file, therapy can begin as soon as a schedule is arranged with the teacher and therapist.
7. The teacher's copy of the therapy IEP should be given to the therapist if direct services will be provided by a therapist
8. Following the ARD/IEP meeting, the provider agency secretary will send a copy of the physician's approval of ARD/IEP committee recommendation (Appendix A-9), outlining the long-and short-term goals and treatment time to the referring physician. He is asked to sign and return the form within one week to the provider agency. Upon receipt, the original will be filed in the student's special education audit folder and a copy will be forwarded to the Health Services Department, UISD.

#8 (continued)

If, after one calendar month, the acknowledgement from the physician has not been returned and attempts to get same have not been accomplished, therapy will be discontinued. The therapist will work closely with the area nurse specialist to insure continuation of services. Two weeks prior to discontinuation of therapy, the UISD OT/PT specialist and parents will be notified by the therapist regarding the status of the form and attempts to contact the physician.

9. If the physician's referral indicated a type of service, amount of time and/or goals that are not in agreement with the therapist's professional judgement as necessary to assist the student to benefit from special education instruction and the ARD/IEP committee cannot reach a consensus, the following must occur:

   A. The ARD/IEP chairperson will contact the UISD OT/PT specialist.

   B. The UISD OT/PT specialist will be responsible for arranging, attending and recording a meeting with the physician, parents, and therapists and an area team member assigned to the school for the purpose of sharing evaluation results, discussing treatment programs offered in the schools, and the student's need for such service to benefit from instruction. (This is at no cost to the parents.) If consensus is obtained, the physician's signature indicating approval will be obtained during the meeting, on the physician's approval of the ARD/IEP committee meeting recommendation form. (Appendix A-9)

   C. Following the meeting, if consensus is obtained, another ARD/IEP meeting must be held. This will be a campus level ARD.

   D. If consensus is not obtained at the campus level ARD, a written report and the ARD/IEP forms and minutes will be forwarded to the Associate Superintendent for Special Education through the Area Associate Director for Special Education for appropriate action.

   E. If there is a mutual desire the UISD will pay for an additional impartial evaluation by another physician.

10. The therapy IEP will be updated along with the instructional update according to the TEA guidelines. The therapists will submit a written update report. These will be mailed to the UISD Health Services and physician as he has requested. If major changes need to be made regarding the treatment goals or altering the number of hours per week, a formal ARD/IEP meeting must be scheduled.

Release from Related Services

The following conditions must be met before a handicapped student is released from a related service:

When assessment is completed for the related service, the admission, review and dismissal committee determines that the student fails to respond to efforts to provide the related service and that the service is no longer needed for the student to benefit from special education instruction and further delivery of the related service to the student is considered inappropriate or inconsistent with the student's best interest.

## INSERVICE TRAINING AND WORKSHOPS

If a request for inservice is received from the UISD area personnel (Principal, Area Associate Director, etc.) or a need is identified by the therapist, the following procedure should be observed:

1. Inservice will be provided only before or after the hours the students are in school.

2. At the building level, the principal notifies the therapist or UISD Area Special Education Staff Development Coordinator of the needs of his/her campus and identifies dates for presentation.

3. The therapist will discuss the proposed inservice with the provider agency, Education Team Coordinator and Assistant Coordinator/Program Assistant regarding the planning of the content and format of the presentation.

4. The therapist will submit in writing to the UISD Area Special Education Staff Development Coordinator with copies to the Area Associate Director, Director of Health Services, and principal (if inservice is for building level only) proposed topics, dates, target groups and audio visual equipment needs.

5. The UISD Area Special Education Staff Development Coordinator will consult with the principal for a building level inservice to confirm the schedule and determine any additional assistance required.

6. At the area level, the Area Special Education Staff Development Coordinator would be responsible for scheduling the date, room arrangement, audio visual equipment, and inviting the appropriate target group to attend the inservice if utilizing the procedure established in their area.

## SCHOOL AMENITIES

1. Therapists should introduce themselves and briefly describe their role to the principal when initiating OT/PT service in the school.

2. Therapists should acknowledge their presence in the school building to the principal every time they enter the school by following the procedure established in that school for itinerant personnel.

3. Therapists should post their proposed schedule of activities with the principal including name of pupil and scheduled time of services weekly. A copy should be mailed in advance weekly to the UISD OT/PT Specialist.

School Amenities (continued)

4. Therapists should contact teachers through school office personnel upon cancellation or change in a student's therapy, group program, etc.
5. Therapists should contact school principal and the specific teacher to set up appointments for screenings anytime during the school year.
6. Therapists will interface with the school nurse in a colleagal manner to share information, treatment goals and areas of concern.
7. A professional manner of dress in accordance with school district policies and provider agency policies is expected.
8. If equipment is needed in treatment areas or if facility adaptation is indicated, the principal should be advised and written request should be routed to provider agency coordinators. Provider agency will forward request to the UISD OT/PT specialist.

## DOCUMENTATION

1. It shall be the responsibility of the provider agency to maintain documentation of service by student's name, type of service provided, scheduled and amount of time. This documentation will be available at all times to the Associate Superintendent of Special Services and/or Executive Director, School Health Services.
2. Each therapist will be responsible for documentation as provided in this procedure manual.
3. The provider agency will submit documentation of student served, time spent and type of service in support of each request for payment.
4. The provider agency will submit documentation of the status of evaluations on a monthly basis.
5. Additional documentation may be required as agreed to by provider agency and UISD.

## PROCEDURE FOR REQUESTING/REQUISITIONING ADAPTIVE MATERIALS/EQUIPMENT TO SPECIAL EDUCATION RESOURCE SERVICES (SERS)

1. The teacher forwards the physician's referral form to the therapist.
2. The therapist evaluates and writes recommendations.
3. The ARD/IEP committee decides programming placement, related services and adaptive equipment needs.

## Procedure for Requesting/Requisitioning Adaptive Materials/Equipment to Special Education Resource Services (SERS) (Continued)

4. If the ARD/IEP committee decides that a piece of adaptive equipment is needed for the student, and the physician has not indicated such on the referral form, the therapist should:

   A. Contact the physician regarding same. If he approves, he will write a prescription for the equipment.

   B. The prescription will be sent to the named therapist at the provider agency.

   C. The provider agency will forward the request and prescription to the area associate director to complete requisition.

5. The area associate director will give the prescription, a copy of the IEP, and the student's qualifying code to the SERS consultant.

6. If pre-purchase evaluation is needed, the SERS will contact vendors.

7. The SERS and therapist will schedule a time for the evaluation with school and vendors.

8. The SERS will write the requisition for equipment according to specifications and will review with the therapist to assure correctness.

9. Requisitions are forwarded to area associate director for signature.

10. SERS consultant forwards requisition to central office.

11. When equipment arrives in the area the SERS coordinator will contact the therapist to set up the appointment for fitting.

12. If re-evaluation indicates a major change in adaptive equipment, the therapist should forward written recommendations to the MDT Leader who will schedule a formal ARD/IEP meeting.

13. If, following an ARD/IEP meeting, equipment is needed, the area associate director will supply SERS with information, and the above process would apply.

# APPENDIX A

# SAMPLES OF
# FORMS
# USED BY U.I.S.D.

# HARRIS COUNTY DEPARTMENT OF EDUCATION OT/PT REFERRAL CHECK LIST

Each child referred should have a significant problem which prevents him/her from benefiting from the educational program.

Child's Name ____________________ School ____________________ Teacher ____________________

Date ____________________ Grade ____________________

Referred by _________ ARD _________ MDT _________ Other Birthdate ____________________

1. Does the child exhibit a readily observable physical handicap which hinders his/her functioning in the classroom? Please check.

_____ tremor
_____ muscle weakness
_____ muscle tightness
_____ abnormal posture or spinal curvature
_____ abnormal gait, e.g., limps, toe walker, feet turn in or out
_____ has diagnosed neuro muscular disorder, e.g., cerebral palsy; muscular dystrophy; or diagnosed orthopedic condition.
NOTE: ____________________

_____ is confined to a wheelchair
_____ is experiencing difficulty with wheelchair, or other special equipment; regarding fit or working parts
_____ utilizes other special equipment. (Braces, crutches.) NOTE: ____________________

2. Does the child demonstrate difficulty in self-help skills? Please check.

A. Feeding
_____ has difficulty holding or using a spoon
_____ does not eat solid foods
_____ drools
_____ has difficulty chewing and/or swallowing
_____ other ____________________

B. Dressing
_____ dressing skills which are not age appropriate
_____ has difficulty with fastener only
_____ other ____________________

c. Toileting
_____ unable to get onto commode independently
_____ needs assistance with related dressing skills
_____ other ____________________

3. Does the child demonstrate difficulty in motor performance and/or perceptual motor skills which interfere with school performance? Please check.

_____ delayed gross motor development
_____ delayed fine motor development
_____ appears uncoordinated, clumsy
_____ withdrawn from other children
_____ has poor eye contact with people or task
_____ is easily frightened by noises or movement
_____ does not like to be touched
_____ is highly distractible, short attention span, cannot sit still
_____ has difficulty following directions
_____ has not established a hand dominance (6 yr. +)
_____ had difficulty tracing or copying
_____ has difficulty eye tracking; turns head instead of eyes
_____ other ____________________

4. What information might an OT and/or PT provide to assist you in working with this student? ____________________

Forward this form to the Principal's office.

A-1

## URBAN INDEPENDENT SCHOOL DISTRICT
## OT/PT DATA SHEET ON REFERRED CHILDREN

DATE: ____________________

THERAPIST'S NAME: ____________________

CHILD'S NAME: ____________________ BIRTHDATE: ____________________

SCHOOL: ____________________

AREA: ____________________

TEACHER/ROOM: ____________________

GRADE/RESOURCE: ____________________

PARENTS: ____________________ PHONE: ____________________

ADDRESS: ____________________

DIAGNOSIS OR CLASSIFICATION: ____________________

IMPRESSION OF SEVERITY: MILD _____ MODERATE _____ SEVERE __________

COMMENTS: ____________________

SCHOOL FOLDER INFORMATION:

_____ PHYSICIAN'S REFERRAL FOR THERAPY XEROX FOR PROVIDER __________

_____ PARENT PERMISSION FOR THERAPY XEROX FOR PROVIDER __________

_____ A.R.D. FORMS (FOR THERAPY)

_____ PHYSICIAN'S APPROVAL OF THERAPY PLAN

_____ ANY RECENT MEDICAL INFORMATION

PREVIOUS THERAPY SERVICES RECEIVED AT: ____________________

DATE: ____________________

TYPE OF THERAPY: ____________________

DISTRIBUTION OF FORMS:

PARENT PERMISSION/PHYSICIAN REFERRAL GIVEN TO: _____ TEACHER: DATE: __________

_____ PARENT: DATE: __________

PARENTS CONTACTED: DATE: ____________________

COMMENTS: ____________________

PARENT PERMISSION/AND PHYSICIAN REFERRAL FORM RECEIVED AT HISD - DATE: __________

XEROX FOR PROVIDER: __________

CHANGE IN SCHOOL LOCATION:

PREVIOUS SCHOOL LOCATION: ____________________

RELOCATED TO SCHOOL: ____________________ AREA: __________

COMMENTS: ____________________

____________________

URBAN INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT SPECIAL EDUCATION DEPARTMENT

## PHYSICIAN'S REFERRAL FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

Date: ______________________________

Student's Name: ____________________ D.O.B.: _________________ Age: ________

Parents: __________________________ Address: _________________ Phone: ________

Physician: _________________________ Address: _________________ Phone: ________

---

DIAGNOSIS/DISABILITIES:

Occupational Therapy: _____Recommended _____Not Indicated

Physical Therapy: _____Recommended _____Not Indicated

CONTRAINDICATIONS AND/OR PRECAUTIONS:

RECOMMENDED GOALS FOR THERAPEUTIC INTERVENTION:

RECOMMENDED ADAPTIVE EQUIPMENT:

I recommend that this child be referred to the OT and/or PT consultant of the Urban Independent School District for evaluation, recommendations and individual or group treatment if indicated by evaluation results and stipulated in the Individualized Education Program. I understand I will have the opportunity to approve the written treatment plan.

Signed: ________________________________, M.D.
Print/Type Name:

To the Physician:

How often do you wish to receive an update from the school?

( ) Annually ( ) Semi-annually ( ) Quarterly

## URBAN INDEPENDENT SCHOOL DISTRICT

## PARENT CONSENT

I hereby grant permission for the following actions concerning my child, ______________________________, to be taken by or under the auspices of the Urban Independent School District:

- My child may be evaluated by an Occupational and/or Physical Therapist.
- My child may receive occupational and/or physical therapy if ordered
  - .. by the physician and
  - .. agreed upon by the ARD/IEP Committee where I will either give or refuse consent.
- The physician or agencies named by me (on this form) may release any pertinent medical or therapy records to the Urban Independent School District.
- The Urban Independent School District may release to the physician or agencies named by me the evaluation results and reports of progress in treatment.

I understand that I will be contacted either in person or by letter or telephone prior to each release of information regarding my child and that I will receive, upon my written request to the Urban Independent School District Health Services Department, a copy of any written information released by Urban Independent School District staff or OT/PT Consultants.

Agencies in which my child has received occupational and/or physical therapy within the last year: ______________________________________________

______________________________________________

______________________________ ______________________________

Signature of Parent/Guardian Date

HARRIS COUNTY DEPARTMENT OF EDUCATION

_______________________
Date

Dear Parent and Doctor:

The Urban Independent School District contracts with the Harris County Department of Education for occupational and physical therapy services for some of the handicapped children who receive these related services. Such services are provided on the basis of time and frequency specified in the individualized education programs (IEP) developed for each child. When scheduling and facilities permit, these services are delivered where the child attends school; in other instances, children are transported to another site for these services. These services are provided by the school district only when it is substantiated that the child needs such services in order to benefit from instruction.

It has been suggested that ______________________________ be considered to receive occupational and/or physical therapy. In order to conduct an appropriate evaluation, school personnel must first have the attached form completed by parent or physician as indicated.

1. The "Physician's Referral for Occupational and/or Physical Therapy Services" is to be completed and signed by the physician.
2. The "Parent Consent" form on the reverse side of the form is to be completed and signed by the parent or guardian.
3. The form is to be returned to the child's homeroom teacher.

Possible evaluations include:

Feeding - chewing, swallowing, hand-mouth skills, special equipment.
Clinical Evaluation - muscle tone, range of motion, reflex maturation, sensation and muscle strength.
Dressing - dressing and undressing skills.
Gait Analysis
Personal Hygiene - toileting and grooming skills.
Sensory Integrative Evaluation - process of the nervous system organizing sensory information for use in life situations such as the classroom, playground, activities of daily living and relationships with others.
Developmental - gross and fine motor skills.
Posture Screening

Should there be an additional charge for having the Physician's Referral completed, please attach the itemized bill to the referral form.

If you have questions, please call me at ________.

Sincerely yours,     APPROVED BY:

_______________________     _______________________
Therapist     Associate Director for Special Education

231

CC: OT/PT Specialist
Attachments

URBAN INDEPENDENT SCHOOL DISTRICT

My child's possible needs for Occupational and/or Physical Therapy have been discussed with me and I do not request such services for

_________________________________ at this time. I understand
Child's Name

that an evaluation by an Occupational and/or Physical Therapist may be requested at a later date, but will not be conducted without my physician's referral and my written request.

_________________________________ _______________
Signature of Parent or Guardian Date

_________________________________ _______________
Signature of Therapist Date

Please return to the child's homeroom teacher.

CC: OT/PT Specialist

# NOTIFICATION OF COMPLETED OT/PT EVALUATION

TO: ______________________________
(School Personnel)

FROM: ______________________________
(Therapist)

RE: ______________________________
(Student)

SCHOOL: ______________________________
(School)

DATE: ______________________________

An __/__ evaluation has been completed. Please set up an ARD/IEP meeting
OT/PT

at your convenience.

# SUMMARY OF OT/PT EVALUATION

NAME: ____________________ RACE/SEX: ____________________

CASE NO.: ____________________ AGE: __________ DATE TESTED: __________

BIRTHDATE: ____________________ GRADE: ____________________

SCHOOL: ____________________ REFERRING PHYSICIAN: ____________________

DISTRICT: ____________________

CONTRAINDICATIONS AND/OR PRECAUTIONS: ____________________

REFERRED BY: ____________________
(School Personnel)

SOURCES OF EVALUATION:

____ Clinical Evalution

____ Developmental Evaluation

____ Reflex Evaluation

____ Sensory Integration Evaluation

____ Self-Help Evaluation

____ Other ____________________
(specify)

SUMMARY OF ____ OCCUPATIONAL THERAPY EVALUATION
(check one) ____ PHYSICAL THERAPY EVALUATION

OBSERVED BEHAVIOR:

SUMMARY OF INTERPRETATIONS:

RECOMMENDATIONS:

____. The decision regarding the provision of specific related services in the area of ____________ ____________ is the responsibility of the ARD Committee.
Occupational Therapy Physical Therapy

____. Attached are copies of individual evaluation reports:

____________________ ____________________
Signature Date

Date Mailed ____________ Follow-Up Call ____________ Follow-Up Call ________

## PHYSICIAN'S APPROVAL OF ARD/IEP* COMMITTEE MEETING RECOMMENDATION

PHYSICIAN: ________________________________________

ADDRESS: ________________________________________

RE: Initiation of Occupational and Physical Therapy Services in Urban Independent Scho
District.

CHILD'S NAME: ______________________ ARD/IEP COMMITTEE MEETING DATE: ________

In order for the student to benefit from instruction at school, the following treatment plan was recommended by a joint committee of parents, school personnel and therapists.

TREATMENT PLAN:

Treatment Time: ________________________________________

Long Term Occupational Therapy Goals          Long Term Physical Therapy Goals

Please sign and return within one week if you agree with the above outlined program. If not in agreement, or for further information, please contact ____________
Therapist's Name
at ________.

________________________________________ ____________________
Physician's Signature          Date

*Admission, Review, Dismissal/Individualized Educational Plan
The above services will be provided because it has been substantiated that they are needed for the pupil to benefit from special education instruction.

# APPENDIX B

## SAMPLES OF
## DOCUMENTATION
## USED BY PRESENT PROVIDER
## HARRIS COUNTY DEPARTMENT OF EDUCATION

HARRIS COUNTY DEPARTMENT OF EDUCATION

Record of Communications with Physicians/Parents

Student ______________________ DOB ____________ School ______________

| Physician/Parent | Date & Time | Means of Contact | Subject | Disposition |
|---|---|---|---|---|
| | | | | |

______________________________
Therapist

## HCDE OT/PT STUDENT ATTENDANCE SHEET

THERAPIST: ____________________

STUDENT: ____________________ SCHOOL: ____________________ AREA: ________

D.O.B.: ____________________ CLASSIFICATION: ____________________

PARENT: ____________________ CONTACT PHONE: ____________________

ADDRESS: ________________________________________

M.D. NAME: ____________________ CONTACT PHONE: ____________________

ADDRESS: ________________________________________

CLINIC NAME: ____________________ CONTACT PHONE: ____________________

(#)

ADDRESS: ________________________________________

TEACHER'S NAME: ____________________

ARD/IEP DATE: ________________________________________

[illegible]E PROGRAM/DAP PROVIDED: NO____ YES ____; DATE(S): ____________________

SCHOOL PROGRAM/DAP Provided: NO _____ YES _____; DATE(S): ____________________

TREATMENT SCHEDULE: ________________________________________

INITIATION OF TREATMENT DATE: ________________________________________

TERMINATION OF TREATMENT DATE: ________________________________________

ATTENDANCE RECORD ____________ SCHOOL YEAR

| MONTH | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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CODE: + = Present 0 = Student Absent A= Therapist Absent H = School Holiday
N = Non-Student Day

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713) 691-4521 T12/8-80

PSYCHOLOGICAL SERVICES DIVISION

## OT/PT SCHEDULE

THERAPIST:____________________ DATE:____________________

|  | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 |  |  |  |  |  |
| 8:30 |  |  |  |  |  |
| 9:00 |  |  |  |  |  |
| 9:30 |  |  |  |  |  |
| 10:00 |  |  |  |  |  |
| 10:30 |  |  |  |  |  |
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| 11:30 |  |  |  |  |  |
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| 3:30 |  |  |  |  |  |
| 4:00 |  |  |  |  |  |

Urban ISD

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713)692-6216 T12/8-80

## PSYCHOLOGICAL SERVICES DIVISION

### OT/PT SCHEDULE

THERAPIST: Donna Nance, LPT

DATE: 3/8/82

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 | Jester Elem.<br>723-2894<br>(Room 2)<br>Independent | Regan Elem.<br>461-2346<br>(Room 12) Group<br>Jodie Ellis | District<br>HCDE | Same as Monday | Same as Tuesday |
| 8:30 | Activities<br>↓ (60) | Josh Youngman<br>Carrie Brooks (45)<br>Teacher Consult (15) | Evaluation | ↓ | ↓ |
| 9:00 | Jessie Anders<br>↓ (30) | Group<br>Sara Adams<br>James State<br>Trudy Urstead (30) | Consultation<br>↓ | ↓ | |
| 9:30 | Ruby Keith<br>Chuck Norton (30) | Consult<br>↓ (15) | ↓ (180) | Motor lab I<br>↓ (30) | |
| 10:00 | Sonja Nash<br>↓ (30) | Group<br>Barbie Thayer<br>John Barston<br>Candy Barden (30)<br>Consult (15) | Regan Elem.<br>Joe Battles<br>Robin Curtis (30) | Documentation (30) | |
| 10:30 | Travel<br>↓ (30) | John Avery<br>↓ (30) | Feeding Observation<br>Consultation | | |
| 11:00 | Morganside Elem.<br>391-4768<br>Harry Maddings (30) | Marcia Red<br>Ted Story (30) | ↓ (45)<br>Lunch | | |
| 11:30 | Nicky Bruce<br>↓ (30) | Group<br>Andi Plummer<br>John Barnes<br>Fay Curtis (30) | ↓ (30)<br>Travel | | |
| 12:00 | Becky Bryan<br>↓ (30) | Consult (15)<br>Lunch | ↓ (30)<br>Jenson Middle<br>523-8630 | | |
| 12:30 | Lunch<br>↓ (30) | ↓ (30)<br>Travel (15) | Consult<br>Harry Gaines<br>Doris Riggs (45) | ↓ | |
| 1:00 | Nancy Crain<br>Bobby Green (30) | Best Middle<br>982-4938<br>Motor lab I | Jamie Astin<br>Carol Hester (30) | Parker Elem.<br>536-4872<br>Motor lab I | |
| 1:30 | Kate King<br>Sue Shearm (30) | ↓ (45)<br>Documentation | Area Meeting | ↓ (45)<br>Documentation | |
| 2:00 | Travel | ↓ (30)<br>Motor lab II | ↓ (60) | ↓ (30)<br>Motor lab II | |
| 2:30 | ↓ (45)<br>Bender Jr. Hi.<br>[illegible] | ↓ (30)<br>Documentation | Independent<br>Activities | ↓ (30)<br>Documentation | |
| 3:00 | Group Preparation (30)<br>Donna Cook<br>Willie Smith | ↓ (30)<br>Independent | | ↓ (30)<br>Independent | |
| 3:30 | Carmen Perez (30)<br>Clean up (15) | Activities<br>↓ (45) | ↓ (120) | Activities<br>↓ (45) | ↓ |
| 4:00 | | | | | |

Urban ISD - Center Based

HARRIS COUNTY DEPARTMENT OF EDUCATION
6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713)692-6216 T12/8-80
PSYCHOLOGICAL SERVICES DIVISION

OT/PT SCHEDULE

THERAPIST: Joyce Green, OTR DATE: 2/6/82

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 | Orwell Center<br>593-2869<br>(Room 802)<br>Planning (30) | Orwell Center<br>593-2869<br>(Cafeteria)<br>Feeding Consult (30) | Orwell Center<br>HCDE | Same as Monday | Same as Tuesday |
| 8:30 | (Room 108)<br>Jan Meadow ↓ (30) | (Room 619)<br>Carey White ↓ (30) | Evaluation | | |
| 9:00 | Harvey Edge ↓ (30) | Donny Jones ↓ (30) | Consult (90) | | |
| 9:30 | Jon Galvan ↓ (30) | Fran Goodwin ↓ (30) | (Room 108)<br>Consult re: | | |
| 10:00 | Esther Gordon ↓ (30) | Gus Harolds ↓ (30) | Betty Smith<br>Carl Schultz | | |
| 10:30 | Bill Trinity ↓ (30) | Ingrid Webb | Maude Engles<br>Susie Barton (30) | | |
| 11:00 | Jerry Masters ↓ (30) | ↓ (45)<br>Teacher Consultation (15) | Independent Activities | | |
| 11:30 | Teacher Consultation (15)<br>Lunch | Lunch ↓ (30) | | | |
| 12:00 | ↓ (30)<br>(Room 213) | (Room 520)<br>Teacher Consultation (30) | ↓ (90) | | |
| 12:30 | Robert Brooks | (Clinic)<br>Dr. Adcock Conference (30) | Lunch ↓ (30) | | |
| 1:00 | ↓ (45)<br>(Room 215) | (Room 213)<br>Teacher Consult (90) | (Room 802)<br>Area Meeting | | |
| 1:30 | Amy Barrow (30)<br>Paperwork | Evaluation | | | |
| 2:00 | ↓ (30)<br>Bus Transport | ↓ (45)<br>Bus Transport | ↓ (115)<br>Bus Transport | | |
| 2:30 | ↓ (30)<br>Clean Up / | ↓ (30)<br>Paperwork | ↓ (30)<br>Paperwork | | ↓<br>Multi-Handicapped |
| 3:00 | Planning (30) | ↓ (30) | ↓ (30) | ↓ | Team Meeting ↓ (30) |
| 3:30 | | | | | |
| 4:00 | | | | | |

# II. SUBURBAN INDEPENDENT SCHOOL DISTRICT POLICY MANUAL: OT/PT PROGRAM

## INTRODUCTION

The Suburban School District OT/PT Process and Procedures Manual was designed to provide a basic structure from which to provide service with efficiency and quality. This manual is intended to serve as a basis from which to further develop and refine this program.

1. Abbreviations:

AH - Auditorially Handicapped
ARD - Admission, Review and Dismissal
DB - Deaf - Blind
ED - Emotionally Disturbed
HCDE - Harris County Department of Education
IEP - Individualized Education Plan
LD - Learning Disabled
MH - Multihandicapped
MR - Mentally Retarded
OH - Orthopedically Handicapped
OHI - Other Health Impaired
OT/PT - Occupational and/or Physical Therapy
PL 94-142 - Public Law 94-142, "The Education for all Handicapped Children Act"
SH - Speech Handicapped
SISD - Suburban Independent School District
TEA - Texas Education Agency
VH - Visually Handicapped

2. Description of Services:

The therapy staff provides the following services, based on the individual classroom and/or student(s') needs:

A. Direct services:

(1) Initial evaluation and re-evaluation.

(2) Treatment planning.

(3) Treatment implementation.

(4) Equipment adaptation.

B. Indirect services:

(1) Program planning.

(2) Home programs.

(3) Teacher, parent consultation.

(4) Physician contact.

(5) In-service training and workshops.

# CONSULTATION PROCESS

Consultation by an OT/PT with the classroom teacher may precede referral for an OT/PT evaluation request by the classroom teacher/school staff. Consultation may be requested in regards to a particular student or group of students. Any student considered for PT services not having a handicapping condition of OH or MH should be referred for PT consultation to determine if an evaluation is warranted.

1. The Teacher Request for Consultation form is provided to the special education teacher by the educational diagnostician. Parent permission for OT/PT consultation is not required.

2. The teacher is to complete the top portion of the form being careful to state specifically and clearly the nature of the request.

3. The teacher returns the form to the educational diagnostician who in turn sends it to the OT/PT lead therapist via the Special Services Department of the administration building.

4. The lead therapist documents each request received on the Tracking Sheet for Consultation form and is responsible for coordinating each consultation request.

5. After receipt of request, the therapist will attend to each request within 15 working days.

6. After consultation with the classroom teacher, the therapist completes the bottom portion of the Teacher Request for Consultation form and signs it at the lower right hand corner of the page.

7. A consultation may end with a one-time visit and/or follow up visit(s). If further intervention is recommended regarding a student(s), the procedure for an OT/PT evaluation is started.

8. The consulting therapist reports her findings to the lead therapist who then completes the consultation tracking sheets.

9. Two copies of the completed Teacher Request for Consultation form is made by the lead therapist; one for HCDE files and one for the OT/PT file in the district. The original form is sent to the Director of Special Services for district filing. A copy may be given to the teacher upon request.

## REFERRAL PROCESS FOR EVALUATION

1. Referral for an OT/PT evaluation is made through the educational diagnostician who will send the parents the following forms to be completed and returned to the diagnostician:

   a. Cover letter to parents regarding OT/PT services

   b. Parent Consent Regarding O.T. and/or P.T. Services

   c. Physical Referral for OT/PT Services*

   *If referral is for PT, this form is required before an evaluation can be performed. If referral is for OT, use of this form is at the OT discretion. Through a physician's referral for occupational therapy is not mandatory, it is strongly suggested in the case of students with orthopedic handicaps, on major medication, or with seizure disorders.

   *Any student considered for PT services not having a handicapping condition of OH or MH should be referred for PT consultation to determine if an evaluation is warranted. (See B. Consultation Process)

2. The educational diagnostician will then forward copies of the parent consent and physician's referral forms to the OT/PT staff.

3. Upon receipt of the above forms, the OT and PT will evaluate the child and make written recommendations.

4. The ARD Committee must then meet to act upon the recommendations.

5. Re-referral Process: Continued Services for Student(s).

   a. The same process of sending forms, etc. for initial evaluation referrals will be followed with students who are being re-referred from a previous year. However, the Physician's Update form should be used instead of the Physician's Referral for OT/PT Services form.

   b. The ARD Form should indicate re-referral for OT and/or PT evaluation. If no ARD Form can be found in the student's school folder, contact the educational diagnostician and inform her/him that OT/PT services cannot be initiated until the ARD Committee re-refers the student and the above process is completed.

## EVALUATION PROCESS

1. The evaluation process begins after the therapist receives copies of the following forms:
    a. Parent Consent Regarding OT and/or PT Services
    b. Physician's Referral for OT/PT Services or Physician's Update (see I.C.1. c. and I.C. 6.a)
2. The therapist contacts the student's teacher to arrange a time for the evaluation. The OT/PT Functional School Screening may be done at this time.
3. The evaluation is administered by the therapist as appropriate for the student. The therapist then sends the original page of the Notification of Completed OT/PT Evaluation to the educational diagnostician.
4. Information from the OT/PT evaluation is reported by the therapist on HCDE evaluation and report forms. Written recommendations are made and goals are established according to educational relevance. The therapist gives her completed evaluation report to the HCDE program assistant for typing.
5. HCDE provides two copies of the evaluation report to the Special Services Department. HCDE retains a copy of the report for its own files. A copy is made for the therapist's personal folder.
6. A copy of the evaluation report will be forwarded to the referring physician by the special service's director's secretary with specific permission from the parent/guardian.

## ARD/IEP PROCESS

1. The ARD Committee meets annually to officially admit a student into special education, review his/her placement, or dismiss him/her from special education. The committee reviews the student's evaluations, present academic performance, information from the parents/guardian, and the need for related services. An Individualized Educational Plan (IEP) is then written including goals and objectives stated for each discipline and the amount of time spent weekly in speical and/or regular education classes and in each related service.
2. The educational diagnostician is responsible for scheduling the ARD meeting and generally directs the meeting.
3. Attending the ARD meeting are:
    A. Educational diagnostician

B. Administrative component - director of special services and/or school principal

C. Instructional component - regular education and special education (resource and/or self-contained) teacher; one of which is considered the educational liaison

D. Parent and/or guardian

E. Student (when appropriate)

F. Others (when appropriate):
Homebound teacher
Speech therapist
Consultant teacher
Counselor
OT/PT
Psychologist
School lawyer
Transportation representative

G. Others at the parent's or student's request (lawyer, private teacher, therapist, etc.

Voting members include A-E.
Those listed under F/G sign IEP forms pertaining to their own discipline.

4. The OT/PT reports evaluation results and makes recommendations regarding OT/PT services. If therapy is warranted, the OT/PT makes recommendations as to type of service needed and appropriate goals of therapy for the IEP.

5. Reports are given by the various disciplines. ARD forms are then filled out and an IEP is written.

6. The IEP is written by the committee on recommendations from personnel of the various disciplines with additions or changes suggested by the parents and/or student.

7. The OT/PT IEP's are updated by the therapist(s) in November, February, and May on the progress review form which the therapist keeps and turns into the district office at the end of the year. Minor revisions in objectives or addition of objectives for those already met can be made at that time. If a revision in type of service or in frequency of therapy is needed, the ARD committee must meet.

8. The therapist will provide written progress reports on those students receiving OT/PT services as needs indicate and at least annually. Progress reports are to be turned into HCDE and a copy will be sent to the district. The special services secretary will send a copy to the referring physician when appropriate and with specific permission from the parent and/or guardian.

## PARENT/PHYSICIAN COMMUNICATIONS

1. The therapist will obtain verbal consent from parent or guardian upon each communication with the physician.
2. Written permission for release of information is obtained on the Parent Consent Regarding OT/PT form, but the parent/guardian should be informed of each contact made.
3. The therapist will keep a written record of verbal communications with parents and physicians on the HCDE Record of Communications from. The original page of the form will be filed in the HCDE student folder at the end of the school year. The NCR copy will be kept in the therapist's personal file of each student.

## MATERIALS AND EQUIPMENT

1. Requests for equipment may be presented to the director of special education for approval.
2. The materials secretary will keep a record of equipment purchased expressly for PT/OT use.

# APPENDIX C

## SAMPLES OF
## FORMS
## USED BY S.I.S.D.

SUBURBAN INDEPENDENT SCHOOL DISTRICT

Date: ____________________

Dear Parent:

Your child has been referred for evaluation in Occupational Therapy (OT) and/or Physical Therapy (PT) through the Suburban Independent School District. If you wish to have your child considered for such service, the forms checked below must be completed:

☐ Parent Consent Form regarding Occupational/Physical Therapy

☐ Physician's Referral Form for Occupational/Physical Therapy

When these forms have been returned to us, your child will be evaluated to determine his/her needs for OT/PT service. You will be advised of the results of the evaluation.

Please return the form(s) in the stamped, self-addressed envelope included in this letter.

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SUBURBAN INDEPENDENT SCHOOL DISTRICT

SPECIAL SERVICES DEPARTMENT

## PARENT CONSENT REGARDING OCCUPATIONAL AND/OR PHYSICAL THERAPY

I hereby grant permission for the following actions concerning my child,

______________________________, to be taken by or under the auspices of the Suburban Independent School District.

Please Check

| Agree | Disagree | |
|---|---|---|
| | | My child may be evaluated by an occupational/physical therapist. |
| | | My child may receive occupational/physical therapy if ordered by the physician and agreed upon by the ARD/IEP Committee, of which I am a member. |
| | | The physician or agencies named by me on this form may release any pertinent medical or therapy records to the Suburban Independent School District. |
| | | The Suburban Independent School District may release to the physician or agencies named by me, the evaluation results and reports of progress in treatment. |

I understand that I will be contacted either in person or by letter or telephone prior to each release of information regarding my child, and that I will receive, upon my request to the Suburban Independent School District, Special Services Department, a copy of any written information released by Suburban Independent School District staff or OT/PT consultants.

Agencies in which my child has received occupational/physical therapy within the last year:

______________________________________________________________

______________________________________________________________

______________________________ ______________________________
Signature of Parent/Guardian Date

SUBURBAN INDEPENDENT SCHOOL DISTRICT
SPECIAL SERVICES DEPARTMENT

SCHOOL HEALTH SERVICES SPECIAL SERVICES DEPARTMENT

## PHYSICIAN'S REFERRAL FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

School ______________________ Area __________ Date ______________________

Student's Name ______________________ DOB ______________ AGE ____________

Parents ______________________ Address ______________________

Phone ______________________ ______________________

Physician ______________________ Address ______________________

Phone ______________________ ______________________

---

DIAGNOSIS/DISABILITIES:

CONTRAINDICATIONS AND/OR PRECAUTIONS:

RECOMMENDED GOALS FOR THERAPEUTIC INTERVENTION:

RECOMMENDED ADAPTIVE EQUIPMENT IF INDICATED:

| | | |
|---|---|---|
| Occupational Therapy: | _____Recommended | _____Not Indicated |
| Physical Therapy: | _____Recommended | _____Not Indicated |

I recommend that this child be referred to the OT/PT consultant of the Suburban Independent School District for re-evaluation, recommendations and individual or group treatment if indicated by evaluation results and stipulated in the Individualized Education Program.

Signed: ______________________, M.D.

______________________
Print or Type Name
Date: ______________________

303

To the Physician:

How often do you wish to receive an update from the school? ( ) Annually, ( ) Semi-annually ( ) Quarterly

## PHYSICIAN UPDATE

I understand that ______________________________________________
Name of Student

received ______________________Occupational Therapy

______________________Physical Therapy

for the school year _________. It _____ is/ ______ is not my recommendation that treatment be continued for the school year _________.

Recommended Goals of therapy program:

New medical or surgical procedures since last referral:

____________________________________
Signature of Physician

____________________________________
School

____________________________________
Teacher

304

## GROUPS - O.T.

Classes to be considered for group therapy:

- ECH
- EMR
- TMR
- Children previously seen in individual treatment
- Minimally involved children previously evaluated or screened by O.T. but not seen

Following receipt of a signed parent permission form (issued by the O.T.R. to teacher to be sent home), each child will be individually evaluated or screened and recommendations made. An ARD meeting will be held to consult with parents, teachers and others regarding need for sensorimotor groups, and an IEP will be written.

Each child's IEP will be updated in November, February and May (as individual children).

On the May update, disposition will be made for the following school year.

# TEACHER REQUEST FOR CONSULTATION

Student's Name ______________________________ DOB ____________________ Age __________

School ________________________________ District ____________________ Referral Date ______

Teacher ____________________________________ Grade _____________

Handicapping Condition ________________________________________

Problem evident in Classroom ____________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Best time for consultation visit and/or student observation __________ / __________
Time / Day

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

(To be completed by therapist)

Date referral received ________________________________________

Contact dates and persons contacted ____________________________________________________

______________________________________________________________________________________

Disposition ____________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Followup ______________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

306

TO: Special Education Teacher

FROM: Director of Special Education

To simplify requests for OT/PT services, teachers may use this form to request therapy consultation regarding student or classroom concerns.

Therapy consultation may be used for any child having difficulty adapting physically to normal classroom activities or settings.

1. Fill out teacher request for consultation.
2. Submit to ________________________________.
3. You will be contacted by an OT or PT who is available on alternating Wednesdays.

## TRACKING SHEET FOR CONSULTATIONS

| Name of Student | Name of School | Name of Teacher | Date of Referral | Date of Consultation | Name of Therapist |
|---|---|---|---|---|---|
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PARENT CONSENT FORM FOR OCCUPATIONAL THERAPY CONSULTATION

I hereby grant permission for my child to have OT classroom consultation. I understand that I will be contacted if any changes are felt necessary in the IEP and I will have the right to give or refuse permission to do so.

Signature of Parent/Guardian ______________________

Date ______________________

# OT/PT CLASSROOM OBSERVATION

SCHOOL: ______________________ DISTRICT: ______________________

CLASSROOM LEVEL: ______________________ TEACHER: ______________________

DATE OF REFERRAL: ______________________ DATE THERAPY STARTED: ______________________

AMOUNT OF CONSULTATION GIVEN: ______________ APPROXIMATE TIME: ______________________

NUMBER OF STUDENTS: ______________________

| STUDENT'S NAME | AGE | MAJOR DISABILITY |
|---|---|---|
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| CLASSROOM THERAPY GOALS | DATE ACHIEVED |
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CYCLE REVIEW DATES

______________________________________________

______________________________________________

______________________________________________

REVISED GOALS

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

OT/PT Classroom Consultation/2

YEAR END REPORT:

ATTENDANCE

| STUDENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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CODE: + = Present   0 = Student Absent

Therapist ____________________ Date ____________________

## DOCUMENTATION FOR REGULARLY SCHEDULED CLASSROOM CONSULTATION

School: ______________________________ Teacher: ______________________________

Date: ______________________________ Therapist: ______________________________

Consultation on the above date was given to the following children:

| Student's Name | Problem and/or Observation | Suggestion Made |
|---|---|---|
| | | |
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SUBURBAN INDEPENDENT SCHOOL DISTRICT Page _____ of _____
SPECIAL SERVICES DEPARTMENT
ARD SUMMARY

The Admission, Review and Dismissal Committee of ______________________________
School, met on behalf of ______________________________, DOB ________________
on __________________________.

Deliberations, Findings and Recommendations:

Intellectual ____________________________________________________
Achievement ____________________________________________________
Other tests ____________________________________________________

Pertinent and/or relevant parent information:

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Pertinent and/or relevant information from school personnel:

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Appraisal Information:

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Alternatives Reviewed:

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Additional services (if relevant discussed:

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

## ARD SUMMARY

## PART II

Page _____ of _____

ASSURANCES:

YES NO (Check one) The Committee assures the following:

____ ____ Student is not assigned to Special Education on the basis of criteria developed soley on the command of the English language.

____ ____ The deficiencies identified are not directly attributable to:

A. A different cultural lifestyle
B. Not having had educational opportunities
C. Not having achieved from previous educational experiences

The Committee's decision regarding ______________________________ from ______________________________, grade level ______________________________, was:

__________ Student does/does not meet eligibility criteria for ______________________________.

__________ TO PLACE this student in a Special Education Program during the school year ____________________. This student will start classes on ____________________, at ______________________________ in grade level ______________________________.

__________ NOT TO PLACE this student in a Special Education Program during the school year ____________________.

__________ TO CONTINUE this ____________________ student in a Special Education Program at ______________________________ grade level ____________ for the school year ____________________.

__________ TO CHANGE this student from Special Education category ____________ to ________________ with continued placement in a ______________________________ at ______________________________.

__________ TO DISMISS this student from the Special Education Program at ______________________________, effective ______________________________.

____________________ Professional Recommendation.

____________________ Parent request.
"As a parent, I understand that no further Special Education services will be provided."

SPECIFIC EDUCATIONAL PLACEMENT INFORMATION (SI, AI, SC, ETC.)

______________________________________________________________

______________________________________________________________

______________________________________________________________

## ARD SUMMARY

## PART III

Page _____ of ____

The ARD Committee ensures that the parent(s) and/or student has had his/her rights explained to him/her, and that all procedural safeguards have been observed.

_______________ YES _______________ NO

I have particpated in all of the decisions listed on the preceding pages on this date _______________________________:

COMMITTEE

| NAME | TITLE | AGREE | DISAGREE |
|---|---|---|---|
| | PARENT | | |
| | APPRAISAL | | |
| | PRINCIPAL or ADMIN. DESIGNEE | | |
| | TEACHER | | |
| | SP. ED. TEACHER | | |
| | OTHER | | |
| | OTHER | | |
| | STUDENT (if appropriate) | | |

If dissenting please comment:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

(SIGNATURE - DATE)

(If the parent of this student was not present at the ARD Committee mtg.) The committee appointed ____________________ to communicate the results of this meeting with the parent.(STAFF MEMBER)

I, the parent or guardian of this student, was not present at the ARD Committee meeting. However, I have reviewed the summary report and have had it fully explained to me. Also, I have had my rights explained to me so that I fully understand.

_________________________ _________

(SIGNATURE OF PARENT) (DATE)

(For initial placements only) I give my permission for ____________________ to receive the special education services described in this plan. I understand that my permission may be revoked at any time.

_________________________ _________

(SIGNATURE OF PARENT) (DATE)

Page _____ of _____

SPECIAL SERVICES DEPARTMENT

SUBURBAN I.S.D.

INDIVIDUAL EDUCATION PROGRAM

ANNUAL GOALS AND SHORT-TERM INSTRUCTIONAL OBJECTIVES

NAME ____________________ SCHOOL ____________________

SERVICES: ____________________

JUSTIFICATION: ____________________

PERSON RESPONSIBLE: ____________________

OBJECTIVES:

Page _____ of _____

SPECIAL SERVICES DEPARTMENT

SUBURBAN I.S.D.

INDIVIDUAL EDUCATION PROGRAM

ANNUAL GOALS AND SHORT-TERM INSTRUCTIONAL OBJECTIVES

NAME ______________________________ SCHOOL ______________________________

SERVICE: ______________________________

JUSTIFICATION: ______________________________

PERSON RESPONSIBLE: ____________________

OBJECTIVES:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

COMMITTEE: DATE: ____________

| NAME | TITLE | AGREE | DISAGREE |
|---|---|---|---|
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SPECIAL SERVICES DEPARTMENT

SUBURBAN INDEPENDENT SCHOOL DISTRICT

ANNUAL FORMAL REVIEW OF I.E.P.

Schedule of Services Recommended for School Year ___/___

NAME ______________________ DATE OF BIRTH ____________

SCHOOL ______________________ CATEGORY ____________

GRADE ______________ (as of ___/___)

Present Level of Performance (All areas may not be applicable):

| Area Measured | Date | Test | Card | Age | Comments |
|---|---|---|---|---|---|
| Infant Stimulation | | Portage | | | |
| Socialization | | Portage | | | |
| Language | | Portage | | | |
| Self-Help | | Portage | | | |
| Cognitive | | Portage | | | |
| Motor | | Portage | | | |

ALL ACADEMIC SUBJECTS: Person Responsible: ____________

Pre-Readiness Level: ________ Readiness Level: ____________

Anticipated Duration of Services ____________ to ____________

Informal Review Schedule: November February May

Total Hours Spent: Regular ____________ Special: ____________

Instructional Arrangement: ____________

RELATED SERVICES RECOMMENDED

| | Service | Time Spent | Person Responsible |
|---|---|---|---|
| ____ | Speech Therapy | ____ min. per week | ____________ |
| ____ | Special Transportation | ____ daily | Transportation Dept. |
| ____ | OT/PT | ____________ | Harris County Dept. of Ed. |
| ____ | ____________ | ____________ | ____________ |

C-12

SUBURBAN INDEPENDENT SCHOOL DISTRICT

SPECIAL SERVICES DEPARTMENT

INDIVIDUAL EDUCATION PROGRAM

## PROGRESS REVIEW

NAME ______________________ SCHOOL ______________________

SUBJECT ______________________

(M=Met/C=Con't/R=Revise)

| GOAL: OBJECTIVES: | Nov. | Feb. | May |
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| Person(s) Responsible: | | | |
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| 320 | | | |
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SPECIAL SERVICES DEPARTMENT

SUBURBAN INDEPENDENT SCHOOL DISTRICT

# REVISION OF INDIVIDUAL EDUCATION PROGRAM

NAME ______________________ SCHOOL ______________________

DATE ______________________ GRADE LEVEL ______________________

Indicate subject(s), change, reason for the change:

| COMMITTEE | TITLE | AGREE | DISAGREE |
|---|---|---|---|
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| SIGNATURE OF DIAGNOSTICIAN | | | |
| SIGNATURE OF PARENT | | | |
| SIGNATURE OF STUDENT (if appropriate) | | | |

# SPECIAL SERVICES DEPARTMENT
# SUBURBAN INDEPENDENT SCHOOL DISTRICT

## INDIVIDUAL EDUCATION PROGRAM
## TOTAL SERVICE PLAN
COVERING ____TO____ (3 Years)

NAME ______________________________ DATE OF BIRTH ________________________

SCHOOL ______________________________ CATEGORY ________________________

CURRENT GRADE LEVEL/COMPETENCY LEVEL

| Subject | | Test | Date Administered |
|---|---|---|---|
| Reading | | | |
| Spelling | | | |
| Math | | | |

STRENGTHS, WEAKNESSES AND EDUCATIONAL NEEDS
Academic/Developmental Skills:

Behavior which affects Educational Programming:

Physical Abilities/Disabilities:

Prerequisite Vocational Skills:

Special and Related Services to be Provided: (Resource, Special Transportation, Occupational/Physical Therapy, Speech Therapy, Counseling, Psychological Services, Adaptive P.E., etc.)

| Service | Justification |
|---|---|
| | |
| | |
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COMMITTEE: DATE: ____________________

| Name | Title | Agree | Disagree |
|---|---|---|---|
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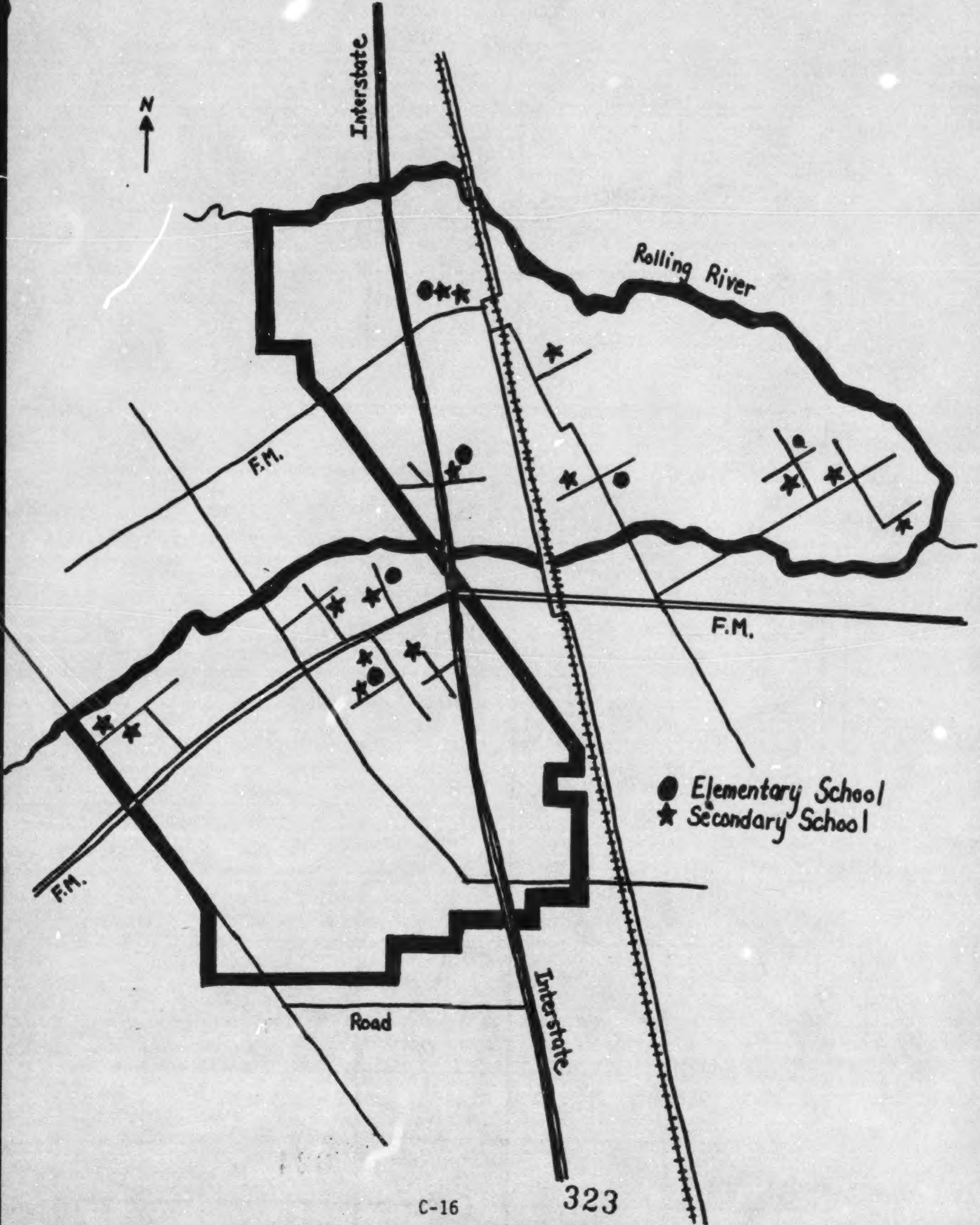
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Interstate
Rolling River
F.M.
F.M.
F.M.
Road
Interstate
● Elementary School
★ Secondary School

Suburban ISD

HARRIS COUNTY DEPARTMENT OF EDUCATION
6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713)692-6216 T12/8-80
PSYCHOLOGICAL SERVICES DIVISION

OT/PT SCHEDULE

THERAPIST: Carolyn Jones, LPT

DATE: 1/4/82

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 | Rolling Creek Elem.<br>546-1462 | Woods Elem.<br>479-3999 | Office/District<br>Woods Elem. | Same as | Same as |
| 8:30 | (Room 21)<br>Consultation<br>↓ (45) | (Stage)<br>Bill Langston<br>↓ (30) | Consultation<br>Jamie Waugh<br>Carlos Garcia | Monday | Tuesday |
| 9:00 | Sara May<br>↓ (30) | (Room 18)<br>Lucy Wells<br>↓ (30) | Sharon Ray<br>↓ | ↓ | ↓ |
| 9:30 | Robert Smith<br>↓ | Vicki Cole<br>↓ (30) | ↓ | ↓ | ↓ |
| 10:00 | ↓ (45)<br>Chris Stanley | (Stage)<br>Jerry Bruce (30) | ↓ (120) | ↓ | ↓ |
| 10:30 | ↓ (45) | Phone calls/<br>Planning (30) | Consultation at<br>Woody Elementary<br>or Pines | ↓ | ↓ |
| 11:00 | Lunch<br>↓ (30) | (Room 18)<br>Kathy Casey<br>↓ (30) | ↓ (60) | ↓ | ↓ |
| 11:30 | (Room 20)<br>Consultation<br>↓ (30) | Lunch<br>↓ (30) | Lunch<br>↓ (30) | ↓ | ↓ |
| 12:00 | (Room 21)<br>Mary Finch<br>↓ (30) | (Room 12-open area)<br>Lynda Sims<br>↓ (30) | Evaluations<br>↓ | ↓ | ↓ |
| 12:30 | (Room 10)<br>Marshal Long<br>↓ (30) | Randall Mitchel<br>↓ (30) | ↓ (60) | ↓ | ↓ |
| 1:00 | One time<br>Consultations/<br>Evaluations/ | (Stage)<br>Evaluations | Shady Elem.<br>564-6300<br>Rex Nance (30) | Travel (15)<br>Moss Elementary<br>264-1742 | Travel (15)<br>Rivers Elem.<br>564-1417 |
| 1:30 | Paperwork<br>↓ | ↓ (60) | Travel (15)<br>Brooks Jr. High<br>864-9711 | (Room 6)<br>One Time<br>Consultations/ | (Room 20)<br>Ryan Cash (30)<br>Travel (15) |
| 2:00 | ↓ (75)<br>Travel (15) | Independent<br>Activities | (Room 3)<br>Consultation | ARD's<br>↓ (60)<br>Travel (15) | Shady Elem.<br>564-6300<br>Independent |
| 2:30 | Jr. High<br>567-7882<br>(Room 6)<br>Mark Romero (30) | ↓ | Randy Stewart<br>Pearl Watts<br>Lynn Riggs<br>↓ (105) | Rolling Creek Elem.<br>546-1462<br>Independent | Activities<br>↓ |
| 3:00 | Travel (15)<br>Rolling Creek Elem.<br>546-1462 | ↓ | Travel (15)<br>Bates Jr. High<br>898-6244 | Activities<br>↓ | ↓ |
| 3:30 | (Room 21)<br>Independent<br>Activities | ↓ | Consultation<br>Dianne Brown<br>Lola Bass | ↓ | ↓ |
| 4:00 | ↓ (60) | ↓ (135) | Tim Sparks<br>↓ (60) | ↓ (120) | ↓ (120) |

# III. PROCESS AND PROCEDURES HANDBOOK
# OCCUPATIONAL THERAPY/PHYSICAL THERAPY
# FOR
# RURAL INDEPENDENT SCHOOL DISTRICT

# INTRODUCTION

The Rural I.S.D. Process and Procedure Manual was written to provide HCDE personnel with an overall view of the present therapy program. It is to be used as a model to provide effective therapy services within the school system. It is also designed to be a baseline to further develop and refine therapy services.

The OT/PT program in Rural I.S.D. services special education students with a variety of disabilities, as determined by T.E.A. guidelines. Students may range from early childhood education classes to high school level. OT/PT service is recommended and/or provided based upon the difficulties the student encounters in the classroom/school setting. Services offered to the district may include:

1. Evaluation/re-evaluation
2. Treatment planning and implementation
3. Consultation with teachers and parents
4. School or home programs
5. Consultation with the director of special education or teachers regarding appropriate OT referrals.
6. Recommendations/fabrication of adaptive equipment
7. Inservice training

## ABBREVIATIONS

ADL - Activities of Daily Living
AH - Auditorily Handicapped
APE - Adapted Physical Education
ARD - Admission, Review and Dismissal
AUT - Autistic
DB - Deaf/Blind
ECE - Early Childhood Education
ED - Emotionally Disturbed
HCDE - Harris County Department of Education
HB - Homebound
IEP - Individualized Education Plan
LD - Learning Disabled
LPT - Licensed Physical Therapist
MDT - Multi-Disciplinary Team
MH - Multi-handicapped
MR - Mentally Retarded
NDT - Neurodevelopmental Techniques
OH - Orthopedically Handicapped
OHI - Other Health Impaired
OT - Occupational Therapy
OTR - Registered Occupational Therapist
PL 94-142 - Public Law 94-142, "The Education for All Handicapped Children Act"
PT - Physical Therapy
RISD - Rural Independent School District
SH - Speech Handicapped
T.E.A. - Texas Education Agency
VH - Visually Handicapped

## Referral Process

1. A student is referred for an evaluation by:
    - a. ARD committee recommendation.
    - b. A teacher or parent may request an evaluation through the director of special education.
2. The director of special education is responsible for having the parent sign the consent form for the evaluation.
3. The director of special education will notify the therapist of the evaluation referral.
4. A copy of the signed parent consent form should be given to the therapist prior to the evaluation.
5. A physician's referral form may be requested prior to the initial evaluation and/or treatment if the therapist decides it is indicated, according to the student's physical status. If so, the director of special education is notified at the time of the initial referral.

## Evaluation Process

1. After the signed parent consent form (and physician's referral if indicated) has been given to the OT or PT, the therapist contacts the teacher, principal and/or other school personnel to schedule an evaluation time and area.
2. The therapist may wish to review the student's state folder for relevant biographical, medical, or school history information.
3. The evaluation is administered by the therapist.

** The educational reason for the referral should be discussed with the teacher as part of the evaluation. If possible, the student should be observed in the classroom and general school environment.

4. It is recommended that the therapist notify the director of special education that the evaluation has been completed, for optimal communication between the district and HCDE.
5. The evaluation report and recommendations regarding service are written. The report is processed at HCDE.
6. The report is sent to the director of special education.

7. A re-evaluation may be done at any time, based on the ARD committee recommendation. It follows the same process as an initial evaluation.

8. A 3-year re-evaluation is mandatory for all students receiving therapy services for 3 consecutive years. It follows the same process as an initial evaluation.

ARD/IEP Process

1. It is the responsibility of the ARD committee to determine whether a student is eligible for OT services based on the recommendations of the evaluation or yearly ARD-Summary report.

2. It is the responsibility of the ARD committee to determine whether OT services will be changed or terminated based on the OT/PT recommendations.

3. There must be at least four members present for an ARD committee, and include one member from a, b, and c (below):

    a. Special education director

    b. Educational representative (teacher)

    c. Appraisal personnel (diagnostician, OT, speech therapist)

    d. Parent/guardian

4. Each member of the ARD committee has one vote, including the OT or PT.

5. It is the responsibility of the OT or PT to report on the results of the evaluation, the student's progress, and to make recommendations concerning therapy services. Frequently, the OT or PT is unable to attend the ARD meeting, and the written reports/recommendations are reviewed by the special education director or appraisal personnel.

6. If the parent is present, the reports of the committee are given by each member with opportunity for questions and comments. A written record is kept of the entire ARD committee proceedings.

7. The parent has the right to accept or reject the ARD committee recommendations. If the parent is not present, a copy of the proceedings is sent to them.

8. If therapy services are recommended and approved, the OT or PT is responsible for developing an IEP with long and short term goals for the remainder of the school year. At the annual ARD meeting (usually held in May) the IEP goals are written for the following year.

9. Frequently, the therapist is unable to attend the ARD meeting. If service is approved by the ARD committee, generally the long-term goal is written as "OT or PT goals to be determined by therapist".

10. If the therapist is unable to attend the ARD meeting, it is the responsibility of the director of special education to inform the therapist of the committee decision.

11. If service was approved, and a general therapy goal written (as above #9), it is the therapist's responsibility to write specific long and short term IEP goals, relating therapy goals to improving classroom/school performance. Originals are put into the student's state folder with copies to the teacher and therapist.

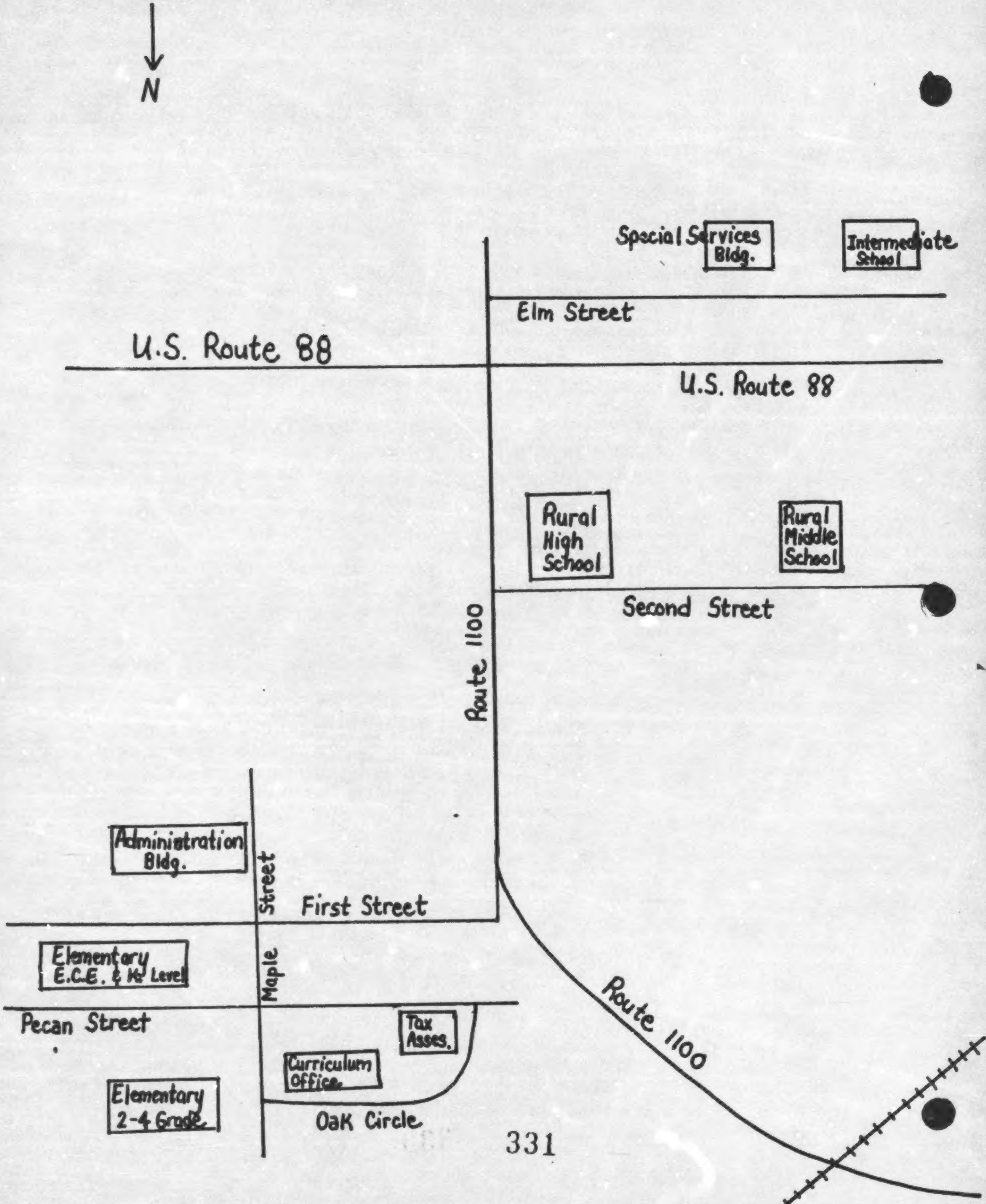
12. In September of each school year, it is the therapist's responsibility to review and revise long term IEP goals on the students approved to begin OT or PT services. Short term goals are to be written, again relating them to maximize school performance.

13. Long term goals remain the same for the entire school year, following ARD committee approval. An ARD meeting must be held to change a long term goal.

14. Short term goals are reviewed and revised if necessary, documenting on the appropriate district form, every 60 school days. All district forms (state folder, teacher, therapist) are documented.

## Materials/Equipment

Presently, requests for adaptive equipment or special materials should be addressed to the director of special education. The therapist may also serve as a resource person if a teacher asks for recommendations on equipment purchases.


N
Special Services Bldg.
Intermediate School
Elm Street
U.S. Route 88
U.S. Route 88
Rural High School
Rural Middle School
Second Street
Route 1100
Administration Bldg.
Maple Street
First Street
Elementary E.C.E. & K. Level
Pecan Street
Tax Asses.
Curriculum Office
Elementary 2-4 Grade
Oak Circle
Route 1100

# APPENDIX D

## SAMPLES OF
## FORMS
## USED BY R.I.S.D.

RURAL INDEPENDENT SCHOOL DISTRICT

Department of Special Education

## PARENT PERMISSION FOR TESTING

In order to provide the best educational program for ______________________________ we would like to evaluate him/her in the following area:

Physical - how well the mind and body work together

SPECIFIC EXAMPLE - evaluation by an occupational therapist

I have been given a copy of the booklet Parent and Student Rights For A Special Education and understand that my consent is voluntary, (freely given) and can be withdrawn at any time.

______________________________
Parent or Guardian Signature

______________________________
Date

## RURAL INDEPENDENT SCHOOL DISTRICT

## DEPARTMENT OF SPECIAL EDUCATION

ADMISSION, REVIEW AND DISMISSAL COMMITTEE SUMMARY OF DELIBERATIONS, FINDINGS, AND RECOMMENDATIONS AND INDIVIDUAL EDUCATIONAL PLAN

STUDIENT: ______________________ DATE OF BIRTH ______ / ______ / ______
Yr. Mo. Day

PARENT/GUARDIAN: ______________ ADDRESS: ______________________

PHONE: ____________ SCHOOL: ____________________ GRADE: ____

I. THE COMMITTEE REVIEWED THE FOLLOWING DATA:

A. Assessment reports (specify reports and dates of reports as attached)

| TEST | DATE | TEST | DATE |
|---|---|---|---|
| WISC-R | | BRIGANCE | |
| WAIS | | PIAT | |
| STANFORD-BINET | | WRAT | |
| BENDER-GESTALT | | | |
| WOODCOCK-JOHNSON | | | |
| KEY MATH | | | |

B. Assessment data or information from the parent or student:

C. Assessment data or information from other school personnel

| Item: | Date: |
|---|---|
| Referral Committee Report | |

Student ______________

II. THE COMMITTEE DECIDED THAT THE STUDENT

______ did not meet any specific eligibility criteria at this time

______ met the specific criteria for the following (check one):

______ orthopedically handicapped
______ other health impaired
______ auditorially handicapped
______ visually handicapped
______ deaf-blind
______ mentally retarded
______ emotionally disturbed
______ learning disabled
______ speech handicapped
______ autistic
______ multiply handicapped
______ pregnant

A. This decision was based on the following data:

______ IQ, ______ Achievement Test Scores, ______ Adaptive Behavior, ______ Medical Reports, ______ Speech & Hearing Evaluation, ______ Psychiatric/Psychological Evaluation, ______ Other (specify)

B. The discussion of eligibility included the following points (specify points and persons making them):

III. THE COMMITTEE DECIDED THAT THIS STUDENT

______ needs special education services because of the handicapping conditions cited above.

______ does not need special education services at this time

The data on which this decision was based include:

______ Psycho-Educational Evaluation, ______ Psychiatric/Psychological Evaluation, ______ Information provided by school personnel (explain), ______ Other (explain)

IV. The committee ensures that this student is not assigned to special education on the basis of criteria which were developed solely on the command of the English language.

______ Yes ______ No

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Student ________________

The committee ensures that this student was not placed in special education if the only deficiencies identified are directly attributable to:

a. a different cultural lifestyle ______ Yes ______ No

b. not having had educational opportunitities ______ Yes ______ No

c. not having achieved from previous educational experiences ______ Yes ______ No

Discussion:

## V. INDIVIDUAL EDUCATIONAL PLAN

A. Present competencies (may reference assessment data if attached)

1. Academic/Developmental
2. Physical
3. Behavioral
4. Prevocational/Vocational

B. Services

| Regular Education | Time | Start | End | Justification |
|---|---|---|---|---|
| Special Education | | | | |
| Vocational Education | | | | |
| Related Services | | | | |

C. Instructional and related services, goals and objectives:

ANNUAL GOAL # ______: ____________________________________________

____________________________________________

____________________________________________

ANNUAL GOAL # ______: ____________________________________________

____________________________________________

____________________________________________

ANNUAL GOAL # ______: ____________________________________________

____________________________________________

____________________________________________

Student ____________

VI. During the development of the individual educational plan, the committee discussed alternative services and recommendations of individual committee members. A summary of that discussion is:

VII. I have particpated in all of the decisions on this date, ____________________.

| SIGNATURE | POSITION | AGREE | DISAGREE |
|---|---|---|---|
| | Parent | | |
| | Administrator | | |
| | Teacher | | |
| | | | |
| | | | |
| | | | |

VIII. (for initial placements only) I give my permission for ____________________, to receive the special education services described in this plan. I understand that my permission may be revoked at any time.

______________________________ ______________________________
Parent's or Adult Student's Signature Date

Student ____________

ANNUAL GOAL # _____ PERSON RESPONSIBLE ____________________

OBJECTIVE # _____: ______________________________________ Quarterly Review*

______________________________________________

______________________________________________

| Nov. | Feb. | May |
|---|---|---|
|  |  |  |

CRITERIA FOR EVALUATION:

SCHEDULE FOR EVALUATION
(if more frequent than quarterly):

---

OBJECTIVE # _____: ______________________________________ Quarterly Review*

______________________________________________

______________________________________________

| Nov. | Feb. | May |
|---|---|---|
|  |  |  |

CRITERIA FOR EVALUATION:

SCHEDULE FOR EVALUATION
(if more frequent than quarterly):

---

OBJECTIVE # _____: ______________________________________ Quarterly Review*

______________________________________________

______________________________________________

| Nov. | Feb. | May |
|---|---|---|
|  |  |  |

CRITERIA FOR EVALUATION:

SCHEDULE FOR EVALUATION
(if more frequent than quarterly):

---

*Review Code

M - Mastered C - Continue C/M - Continue with modification

D - Discontinue, inappropriate

Rural ISD

# HARRIS COUNTY DEPARTMENT OF EDUCATION

6515 IRVINGTON BOULEVARD HOUSTON, TEXAS 77022 (713)692-6216 T12/8-80

PSYCHOLOGICAL SERVICES DIVISION

## OT/PT SCHEDULE

THERAPIST: Linda Smith, OTR

DATE: 11/25/81

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|---|
| 8:00 | | Special Service Office<br>357-1711<br>(30) | | Special Service Office<br>357-1711 | |
| 8:30 | | Rural Elementary<br>456-1622<br>(Gym)<br>Motor Class I (30) | | (45)<br>Travel (15) | |
| 9:00 | | Leigh Jones<br>(30) | | Highway Park Elem.<br>357-1234<br>(Gym)<br>Motor Class II (30) | |
| 9:30 | | (Lounge)<br>Parent/Teacher<br>Consultation | | Jr. High<br>364-4333<br>(Room 8)<br>Kim Street | |
| 10:00 | | (60) | | (45)<br>Travel (15) | |
| 10:30 | | Travel<br>(30) | | Bedview Elem.<br>354-4255<br>(Gym)<br>Motor Class I (30) | |
| 11:00 | | Green Elementary<br>546-1833<br>(Room 6)<br>Motor Class I (30) | | Motor Class II<br>(30) | |
| 11:30 | | Motor Class II<br>(30) | | Lunch<br>(30) | |
| 12:00 | | Lunch<br>(30) | | Motor Class III<br>(30) | |
| 12:30 | | Special Service Office<br>357-1711<br>Parent/Teacher<br>Conference (30) | | Travel (15)<br>High School<br>354-[illegible] | |
| 1:00 | | Consultations<br>(30) | | (Room 9)<br>Cliff Smith | |
| 1:30 | | Evaluations | | (60) | |
| 2:00 | | (60) | | Travel (15)<br>Special Service<br>357-1711 | |
| 2:30 | | Meeting with<br>Contact-Person<br>(30) | | Parent<br>Conference (30) | |
| 3:00 | | Independent<br>Activities | | Teacher<br>Consultation | |
| 3:30 | | (60) | | (60) | |
| 4:00 | | | | | |